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ABSTRACT

Profiles are provided for innovative public health activities that focus on the health of children in day care. All are considered to be models worthy of replication. Profiles depict (1) child care in Arizona; (2) child day care licensing in Connecticut; (3) safeguarding children in day care in Kansas; (4) paired state and local inspection in Maryland; (5) the Massachusetts Preschool Health Program; (6) developing and implementing licensing regulations for Mississippi; (7) centralized licensing in public health services in New Hampshire; (8) training of day care center personnel to perform health screenings in Baltimore; (9) building partnerships between health care providers and other professionals in Dallas; (10) an integrative approach to child care licensing by a city-county health department in Lawrence, Kansas; (11) child care and public health in Marin County, California; (12) meeting the health needs of children attending day care in Minneapolis; and (13) communicable disease management and first aid/accident prevention training for day care sites in Seattle. Comments are provided on the profiles, as well as suggestions for future activities, annotated citations of supplementary material submitted by profile authors, summaries of 23 states' responses to questions about current public health activities, and mini-profiles of the health activities of 18 states. (RH)

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Health of children in DAY CARE

Public Health Profiles

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Health of children in day care

Public health profiles

PS 016435

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KANSAS DEPARTMENT OF HEALTH
AND ENVIRONMENT

December 1986

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Preface

4

A priority for the Administration for Children, Youth and Families is strengthening American families with an emphasis on economic and social self-sufficiency. Child care is recognized as an integral part of this goal and is related to reduced welfare dependency, higher earnings, and the potential for learning and developmental gains.

Today, with nearly 70 percent of the women with school age children and 54 percent of the women with preschool children working outside their home, the demand for quality child care services is growing. By 1990, the number of preschool children with both parents in the labor force will increase by over 2 million or 36 percent and the number of children of single working parents will increase by over a million or 57 percent.

The Administration for Children, Youth and Families has played an integral role in the development of quality child care programs. Twenty years of research and testimony on the Head Start program have illustrated the benefits of this comprehensive, four-component program providing education, health, parent involvement and social services in support of preschool-aged children from low income families. Through the provision of health services (medical, dental, nutrition and mental health) to all enrolled children, the Head Start program continues to demonstrate the Administration's strong commitment to health and safety in child care programs.

The Administration for Children, Youth and Families is committed to federal, state and local public health agencies working cooperatively to strengthen health and safety in child care programs. We are pleased to have this opportunity to co-sponsor the development of "Health of Children in Day Care—Public Health Profiles." The projects described in this publication represent successful models developed by State and local public health agencies in support of health and safety activities. It is our hope that this publication will serve as a model to other public health agencies in their efforts to strengthen health services in child care programs.

Dodie Livingston, Commissioner
Administration for Children, Youth and Families

Phyllis Stubbs, M.D., M.P.H.
Director, Health Services
Health Start Bureau

Child care by other than parents has become a basic need for the majority of American families. The quality of their children's care is a basic concern to them, to care providers, and to those in the community who have responsibilities for safeguarding children's development, health and safety. Long term benefits can be gained from settings that provide enriching developmental experiences and promote healthful living practices in safe environments. Conversely, children may suffer, sometimes permanently, when their care is poor, inappropriate and inconsistent. Parents require assistance to select the child care option that will strengthen their family and assure that their children are not alone fending for themselves.

While the responsibility for a child's health and welfare ultimately rests with the parents, public health programs traditionally have had concerns for children who must depend upon others to provide their care or who must remain alone during parts of each day. Safeguarding and upgrading their health and safety can be fostered by licensing and registering child care programs and by helping families to find suitable placements for the care of their children. The agency or complex of agencies responsible for insuring that licensure or registration standards are met and enforced in various types of child care settings differ from state to state. Therefore, no one model can serve all situations. Regardless of where the official responsibility rests, public health agencies are expected to assume a leadership role in encouraging realistic standards that safeguard and promote the health and safety of children whether through licensure, registration, consultation or technical assistance activities. Individuals who want to care for children must be helped to raise their standards to an acceptable if not to an exemplary level of performance. Licensure or registration must be approached in a manner that encourages care providers to offer safe and enriching care, and to improve their programs and settings accordingly.

Criteria, standards and performance measures for child care programs are designed to protect the child, parent, owner and staff of the child care setting. To encourage initiation of child care programs and to insure their survival, consider the following when reading this publication and when establishing child care criteria, standards and performance measures.

Each criterion must address the maintenance or improvement of a specific health status concern.

The standard for each criterion must be scientifically sound and financially feasible.

Observable performance measures must be determined for each standard.

Periodic monitoring of each standard must be conducted.

Internal and external monitoring must be encouraged, permitted and conducted.

Mechanisms for negotiating for positive daily practices and environmental changes must be available to parents, owners, staff, official agencies and others.

Methods for evaluating the effects of the changes in the environment and daily practices on the health and safety of the children must be planned and conducted.

The Division of Maternal and Child Health is pleased to join the Administration for Children, Youth and Families in making possible this conference and publication. This collaborative effort attests to the assertive approaches that our agencies are taking to promote and safeguard children of this nation who are dependent upon child care providers to safeguard and nurture them during some part of each day.

Vince L. Hutchins, M.D.
Director, Division of Maternal and Child Health

Geraldine J. Funke, R.N., M.S.
Director, Infant and Early Childhood Health Program

5

Introduction

"Ours is a story, or rather a series of stories, largly untold, of innovative public health programs for children in daycare.

Patricia T. Schloesser, M.D., F.A.A.P.

Ours is a story, or rather a series of stories, largely untold, of innovative public health programs for children in day care. We invite the reader to sample a variety of approaches to safeguard and promote the health and well-being of day care children used by real people in actual state and local public health agencies across the country. Thirteen program profiles are offered to reflect a wide diversity of activities in day care which could be replicated by the broader public health community.

In increasing numbers, as their mothers take up employment, young children are spending their days away from their own homes or relative care. Day care has emerged as an alternate to home care for child rearing today, with almost 30% of preschoolers receiving out-of-home care by non-relatives in day care homes or centers. This clustering of preschool children in recognized day care facilities generates new concerns for the children's health, while at the same time presents unique opportunities for public health to extend preventive services to an age group often hard to reach.

Public health has a long history of involvement with day care programs for children. Today's day care programs originated in the nineteenth century with the establishment of day nurseries for the custodial care of poor children and the part-day group education of preschoolers, known as kindergartens. The day nurseries were operated under charitable auspices by social agencies and regulated by local sanitary codes such as those in New York City in the 1850s. A primary concern then, as today, was the potential for spread of infections, so special attention was given to sanitation inspections, food handling, and control of communicable diseases. In the twentieth century, group education of preschool children in the form of nursery schools became a popular supplement to home care for middle income families. Public health played a lesser role with these lower risk, part-day educational services, except for intervening during outbreaks of infectious diseases. There were natural linkages, however, between maternal and child health developmental services and nursery schools or preschools which fostered optimal growth and development.

Publicly run full-day care centers for working families emerged during the depression years, largely through funding by the Works Progress Administration. When licensing of child care facilities received an impetus from Title V of the Social Security Act, enacted in 1935, it became identified as a child welfare service. At that time it seemed logical for social welfare rather than the health agency to assume this "protective" role, as the few children in full day care were poor, often AFDC recipients, and in need of other social services. With the exception of states and cities where public health had the legal mandate for licensing, most public health agencies were peripherally involved by assisting the licensing authority with health and safety standards, consulting on communicable disease and performing sanitation inspections.

World War II gave further impetus to full day care programs, often located at or near factories, hospitals or community centers, so that women with young children could join the war effort. Although many of these centers closed after the war, the need for full time day care remained as women continued in the work force in ever-increasing numbers.

During the 1950s privately sponsored centers and homes emerged, as families with two incomes became able to afford this type of care. Public policy discussions about day care at the 1960 White House Conference on Children and Youth and a national conference on day care in 1962 led to numerous activities to strengthen day care services. Health, mental health, welfare and education agencies collaborated to develop standards, and many states enacted or updated legislation to license day care facilities. Federal initiatives established the Head Start Program for the disadvantaged, retraining programs for women entering the work force, a child care food program, a child care tax credit, and employer tax incentives. In addition, funding of day care services for poor families was increased. Accompanying these initiatives were the federal interagency day care regulations, which were repealed in 1981 when various federal responsibilities were transferred to states.

A more recent development is the provision of on-site day care by the corporate sector, day care information and referral services for the general public, vouchers for employees to obtain off-site day care, a variety of latchkey programs for school age children and special sick child care facilities. As day care became used by all segments of society, consumer protection issues surfaced calling for public health intervention, much as they have occurred in the past for restaurants, hospitals, schools, and nursing homes.

In the 1980s, at a time of decreasing federal support for day care, a national spotlight was turned on the risks occurring in day care facilities: infectious diseases, accidents, child abuse and neglect. Public health, which had been relatively quiescent for a decade, was suddenly called upon to find solutions to problems which had erupted in day care programs.

At the 1984 National Conference on Infectious Diseases in Day Care held in Minneapolis, the major themes which emerged were the importance of environmental and staffing standards, basic hygiene measures, improved prevention and management of infectious disease, and training of child care providers. Also highlighted was the potential for improving the health of children in day care by immunizations, health assessments, screening, nutrition, and special programs for the handicapped. Health organizations including the American Academy of Pediatrics, the American Public Health Association, the Communicable Disease Center of the Public Health Service, and the Division of Maternal and Child Health, and the Administration of Children, Youth and Families of the Department of Health and Human Services showed a renewed interest in addressing health and safety issues in day care.

Although many public health agencies have been active in safeguarding and upgrading the health of

children in day care, there has been very little systematization of those operations and minimal reporting to the professional field of public health or to the community generally. Some important questions need answers: What is public health doing today to protect and promote the health and safety of children in day care? Are there some public health programs which could serve as models for others? How can this information be shared to encourage greater involvement by public health? This project, *Health of Children in Day Care—Public Health Profiles*, is designed as a beginning response to these questions. The Kansas Department of Health and Environment was selected to spearhead this effort because of its continuous experience since 1919 of licensing day care facilities as a maternal and child health service, and the staff's working knowledge of other public health day care service across the country. The primary goal of this publication is to present a number of successful models which can be replicated. It is our hope that other public health agencies will be encouraged to take the lead in improving the health of children in day care.

In addition to the end product of a publication, the dynamics of the project year are worth recounting since they were designed to create widening circles of interest in the health and day care community. A core multi-disciplinary part-time staff was responsible for the steering of the project; namely "your introducer," a public health pediatrician; Marge Petty, a health educator; Norris Class, a social scientist and noted child care licensing specialist; Shirley Norris, a child development specialist; and Pam Carpenter, an administrative assistant. Also of importance was the counsel and support of Barbara Sabol, Secretary of the Kansas Department of Health and Environment, and also a nurse with extensive experience in day care programs. Special health consultants provided guidance throughout the year—Dr. Glen Bartlett and Dr. Al Chang, American Public Health Association; Dr. Susan Aronson and Dr. George Sterne, American Academy of Pediatrics; and Mrs. Geraldine Norris Funke and Dr. Phyllis Stubbs from the Department of Health and Human Services. Jointly this staff identified public health programs which would be geographically representative, diverse in programming and could serve as models for the potential role for public health in day care. Within two months thirteen public health agencies, seven state and six local, enthusiastically agreed to develop a program profile with a core theme and to participate in a two day profile conference. Since these thirteen agencies might not fully represent the full spectrum of activities, it was decided to do a "quick inquiry" to state Maternal and Child Health and Crippled Children's Programs to gain some "beginning intelligence" of the range of activities occurring in the states. Besides gaining this information, a major rationale for the inquiry was to stimulate state programs to focus more attention on the day care population. The response was gratifying with 60% reporting.

The profilers were asked to submit their article prior to the profile conference for review by the special consultants. Each profile was also shared with all participants before the conference. The conference was held in Kansas City, Missouri on March 3 and 4, 1986. Although the project underwrote expenses for one person from each profile agency, three agencies elected to send additional representatives at their own expense. There were also inquiries from state agencies and schools of public health for permission to send persons to audit. This was a hard working group at the conference. The profilers presented their programs which were critiqued by the APHA and AAP consultants. A free discussion by all participants followed with suggestions for changes or different emphases. The final afternoon, open discussion occurred regarding major themes and future directions. The conference evaluation received a high rating with the caveat that there was not enough time to discuss all issues. It was agreed a repeat conference should be held.

The major themes which emerged from the conference discussions were an expanded role for public health, management issues and policy formulation. The various roles presented by the profile studies can be grouped under three categories: direct services for children, parents and providers, community organization and regulation. It appears that a legal base for involvement with day care either as the state licensing authority or through local public health codes sensitizes agencies to expand non-regulatory preventive services to the day care population. It should be noted that six of the seven profile states do have licensing authority, yet report a variety of associated health promotional activities. The other public health profiles portray creative ways in which public health agencies can work in concert with the licensing authority to promote the health of children in day care. Public health prevention programs and child care licensing programs have much in common as both are oriented

to the future, both focus on the entire community or a large section of the population, both are based on a validated common sense idea of causation and the administration at times requires a show of authority.

Following the conference the profilers revised their chapters, incorporating suggestions made during the conference discussions. As a look to the future the medical consultants have provided a summary statement for the publication. The project secured the help of an advertising and graphic design agency (Admark, Inc., Topeka, Kansas) to complete the final editing and to develop an attractive publication with original illustrations designed to "entice" the reader. (State profiles are presented first in alphabetical order, followed by local profiles in the same manner.) The appendix material consists of 1) annotated citations of all supplementary material submitted by each profiler, with the address and telephone number for ready communication by the reader; 2) summary of the inquiry to state Maternal and Child Health offices with selected "mini-profiles," to further portray the scope and diversity of public health programing; 3) brief bibliography for beginning references on health and safety issues in day care regulatory administration and the innovation and diffusion theory; and 4) short listing of major organizations concerned with the health aspects of day care.

These public health profiles present a myriad of services which collectively tell a story of public health contributions designed to improve the health and safety of children in day care. It is our hope that this publication can contribute to the diffusion of innovations throughout the public health community so that these ideas will become commonplace nationally.

As a final word, may I express my appreciation to the core staff, our federal and medical consultants, the profilers and conferees who made this work so enjoyable.

Pat Schloesser, M.D. F.A.A.P.

Table of contents

Preface 3
Introduction 7
Child care in Arizona 15
Child day care licensing program in Connecticut 25
Safeguarding children in day care—the Kansas experience 33
The paired inspection in Maryland
A useful tool in building licensor reliability 41
The Massachusetts Preschool Health Program: an initiative in collaboration 51
Developing and implementing licensing regulations for Mississippi
An example using nutritional standards 61
Centralized licensing in public health services in New Hampshire 67
Training of day care center personnel to perform health screenings in Baltimore . . . 77
Building partnerships in the professional community for Dallas 85
An integrative approach to child care licensing by a city-county health department—Lawrence 93
Child care and public health in Marin County 99
Meeting the health needs of children in day care for Minneapolis
A multi-disciplinary team approach 107
Communicable disease management and first aid/accident prevention training in day care in Seattle 115
Summary comments 125
Annotated citations of supplementary material submitted by profile writers 131
An inquiry into the health of children in day care 137
Mini-profiles 141
Selected bibliography 145
Participant list 149

Child care in Arizona

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ABSTRACT

For 20 years, 1966 to 1986, the Arizona MCH program has grappled with certain early childhood themes:

The educational/developmental quality of day care programs

In-state advocacy for improved opportunities for children

Parent education and parent involvement

An early childhood voice within the state health structure

The program's continuing goal has been quality child day care. Means of accomplishing this goal have included:

- Organizing, and stimulating strong advocate organizations made up of providers, parents, academic leaders, church leaders, and public agency officials
- Directly or indirectly assisting the origination of private agencies who could provide training, monitoring, and upgrading of day care programs far in excess of what could be accomplished by the state or local governmental agencies
- Being constantly in readiness to move into a supportive position at the right time for significant new developments, e.g. Arizona State 4-C Committee, Arizona Save-a-Child League, and the Governor's Council on Children, Youth and Families
- Developing and conducting parent-oriented training and educational activities using staff of the State MCH program, assisted by related units of the State Health Department or associated agencies
- Maintaining within the State MCH unit, a single focus for all early childhood concerns, in the person of the MCH Early Childhood Consultant
- Insuring longevity of the early childhood effort within MCH by aligning the early childhood activities with the most unassailable portions of the total program
- Keeping the early childhood effort in close personal touch with the community's early childhood leaders, thus maintaining a strong constituency as a base of support

It has been the Arizona experience that the addition of an individual with specific training and experience in early childhood education to the State Maternal and Child Health staff will repay benefits, measured in enrichment and improvement of the program, far beyond initial expectations.

In Arizona, the activities of a single early childhood consultant located in the MCH program, maintained over 20 years with Title V funding, and recently broadened by program expansion and align-

ment with high-risk infant concerns, have enabled both state health department and outside agencies to achieve substantial improvements. A broad scope of parent-teaching and parent-advocacy efforts is continuously in place. Strong, vigorous early childhood organizations are active and expanding.

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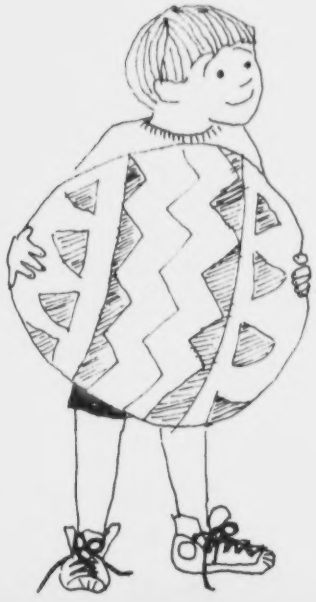
INTRODUCTION

Arizona, with a current population of about 2.5 million, has been among the five most rapidly-growing states in the country over the past 20 years. The major portion of this explosive increase in Arizona citizens has settled in the two major urban centers of the state: Phoenix (and surrounding suburban communities) and Tucson. The balance of the state is sparsely populated, and for the most part is desert terrain, with contrasting mountain areas across the north central and eastern portions.

Arizona is also a young state, in spite of its reputation as a focus for retirement communities. The median age of the population is below the national average, with the preponderance of new residents being young families. The pre-school population numbers approximately 260,000. Mirroring the trend being observed nationally, more than 50% of women in Arizona are employed in the work force.

To accommodate the growing need for child day care, the increase in the number of child care facilities has kept pace with the growth in population. Currently there are about 750 day care centers (licensed by the state to care for five or more children), and 1200 day care homes (caring for fewer than five children, not subject to state licensure but certified by the state social service agency for placement of low-income children).



Currently, and for the past 20 years, day care center licensing has been carried out by the State Health Department's Division of Health Resources/Health Facilities. The Division's Office of Child Day Care Licensing, with a staff of eight surveyors, is headed by an Office Chief who reports to the Division Director, who in turn reports to the state Director of Public Health.

The Department's Office of Maternal and Child Health, the focus of activities described in this paper, is organizationally removed from the licensing function. It is part of the Division of Family Health Services, with the Chief of MCH reporting to the Division Director, and he in turn reporting to the Director of Public Health. This structure has not represented a significant barrier to communication over the years. In fact, the separation of the MCH staff's early childhood consultant from the day care licensing staff has proven to be advantageous in terms of community involvement, advocacy, consultation with centers, and credibility.

Over time, a few issues have been considered of paramount importance by the Arizona Public Health leadership:

A. In 1966, the day care licensing statute passed by the Arizona legislature was seen by many political, health and citizen leaders as applicable only to children placed in day care and paid for by the state welfare department.

The State Health Department, responsible for developing regulations for issuance of licenses and monitoring of care in centers, was operating from a viewpoint limited to fire safety and sanitation standards.

B. Early childhood advocates, concerned about a broader view of the emotional and developmental, as well as the purely physical health aspects of child day care programming, were few in number and lacked organizational strength.

C. Parents of children in day care had virtually no exposure to the issues of quality programming versus custodial day care. Opportunities to involve the parents in such activities were extremely scarce and official efforts to involve parents to create change did not exist. Educational offerings to parents on health matters were also virtually non-existent.

D. As recently as 1982, Arizona law prohibited school districts from using state dollars to offer any sort of educational program for children below kindergarten age. This virtually prevented the development of any public programs for developmentally handicapped children.

E. Creation of the block grants in 1981, with the accompanying relinquishment of virtually all federal priorities or requirements (in favor of state determination), placed MCH activities such as early childhood emphasis and day care parent training in a more precarious position.

The material which follows defines those issues, and describes the manner in which they have been addressed.

COMMUNICATION

For 20 years the Arizona MCH Program has had a continuing focus on issues of early childhood. This component had its origin in 1966, when the entire MCH staff consisted of a Medical Director, a Public Health Nursing Consultant, a Nutritionist, a Hearing Program Consultant, and a Perinatal Mortality Researcher. As is so often the case, the involvement in early childhood and in child day care issues came about not through deliberate planning on the part of the MCH unit, but as the result of a crisis. That crisis was the state legislature's passage of a law requiring that child day care centers be licensed, with responsibility for developing licensing standards and regulations given to the Health Department. It was recognized that the initial development of regulations could best be accomplished by establishing a position for a Child Day Care Consultant, and since the only available funding for such a position came from Title V, the position was placed in the Maternal & Child Health Bureau.

The development of the job description and qualifications for this position proved to be critically important in the ultimate impact to be made. It allowed for the selection of an individual with some background in the health field, but not limited totally to that area, resulting in the hiring of a person whose primary frame of reference was early childhood/child development. This type of background provided a more holistic approach to the problem. One of the strengths that the newly hired consultant brought to the Arizona program was an ability to mobilize leaders in the Day Care and Early Childhood field to assist the Department as programs were developed.

From the outset the MCH Program was concerned that parents be involved in most aspects of out-of-home care for young children. So, once the initial licensing regulations had been developed and adopted (and responsibility for their enforcement turned over to the Department's Licensing section), the consultant began attending to those issues which have represented the thrust of MCH involvement from that time until the present. The attitude among Arizona's Public Health and political leaders concerning early childhood issues was mostly one of apathy. There was little understanding of the scope or importance of early development. The MCH Program, through its Early Childhood Consultant, was challenged to change that perspective.

The Early Childhood Consultant developed an orientation program for prospective day care center operators. This orientation was carried out both in informal and formal settings. The informal presentation was done on a one to one basis, through appointments set up in the consultant's office. The more formal segment consisted of regularly scheduled group sessions, held in both Phoenix and Tucson, to which all individuals who had indicated their intention of beginning a center were invited. These orientations became widely known and were popular. They were designed to answer practical questions regarding programs, child development forms and requirements to meet state licensing standards, but, in addition, always included an emphasis on parent involvement.

Within two to three years the need for a regular means of communicating with centers, day care homes, and parents around the state became obvious. Thus was conceived and created a quarterly newspaper called "KIDBITS." "KIDBITS" contained a potpourri of information, announcements, even sermons, pertinent to the concerns and interests of those involved in early childhood. The newsletter has been continuously published since the early 1970's and at the present time is sent to over 750 day care centers and over 1200 day care homes. Many centers duplicate pertinent articles and materials from the newsletter for distribution to parents. In this way, MCH's message to parents is most efficiently provided to them.

Another, more extensive publication, was first created in 1973 and was entitled "The Day Care Manual." This volume represented several years of work in consultation with all members of the State MCH staff. The manual is primarily designed for the operators and owners of day care centers throughout the state. It was particularly useful for those beginning a day care center, but was very favorably received by those who had operated a center for years. There were sections on center administration, a health care program, an infant and toddler program, child growth and development, staff training, housekeeping, and the current Arizona Licensing Law and Regulations. Throughout each of these sections, which total over 100 pages, there is a recurring message concerning parent involvement in each of the above aspects of child day care. The manual is still in use, has been through several revisions, and is frequently alluded to by long time day care operators as "The Bible" of the Arizona Child Day Care Field.

Because of its geographic configuration, Arizona faces problems with development of all sorts of services in its outlying rural areas. This is no less true of child day care. The MCH program has traditionally been particularly sensitive to the need to spend time with the rural areas of the state. The Early Childhood Consultant traveled extensively to the outlying areas providing individual consultation, presenting workshops and assisting local communities in the coordination of their resources. For a period of time in the early 1980's, a regular presentation was put together and taken to many of the state's communities; it was called "Health Screening—An Investment in Your Community." The presentation, which took an entire day, consisted of: general information about

health, about screening programs, and about immunizations, presented by the Early Childhood Consultant; a section on nutrition, with nutrition screening, presented by one of the staff nutritionists; a section on available community resources, assisted by local individuals; and a practical session on hearing screening, presented by an MCH audiologist, emphasizing the role of parents in the detection of hearing problems in their preschool age children.

NETWORKING

In the late 1960's, The Early Childhood Consultant assisted in the mobilization of others who had early childhood backgrounds and were concerned about the quality of child care to form an organization called the Early Childhood Council. This method of operation was the forerunner of many similar efforts by the MCH Program over the years. Concerns of early childhood education were never among those priority items with which the State Health Department concerned itself; rather it was always with great difficulty that the goals and objectives were even made clear to the Public Health establishment. This being the case, the Arizona MCH Program found that it could be most effective by working through others: by facilitating the creation of programs, often through other agencies, but always with assistance and support from the MCH Unit.

MCH played an important role in the development and acceptance of the Child Development Associate (CDA) program in Arizona. Specifically, the Early Childhood Consultant performed the following functions:

1. Participated in the competency formation process in Arizona, which involved a number of statewide meetings conducted by national people. The group formulated and reviewed drafts of the CDA competencies.

2. Organized and conducted two regional meetings to familiarize various professionals and governmental agency people with the program, and to gain their support.

3. Worked successfully for inclusion of the CDA certificate as a qualification in the child day care center licensing regulations.

4. Provided a resource for information about the CDA program for people interested in entering, and publicized and promoted it extensively. This is still being done by the current consultant.

In like manner, MCH was very supportive of the growth of the local chapter of the Association for the Education of Young Children. In recent years, as networking among early childhood proponents has become more and more prominent in the MCH Program, the contacts found in the regular meetings of AEYC are most valuable.

Perhaps the ultimate example of parent and voluntary agency/advocate involvement in early childhood issues in Arizona began in 1982. This is the utilization of the annual Week of the Young Child as a time for a saturation campaign for early childhood issues throughout the state. The Arizona MCH program, working closely with the Valley of the Sun Chapter of the Association for Young Children, has managed to develop an extensive statewide celebration with participation by literally thousands of individuals, targeted directly at parents of young children. A multitude of participatory activities and happenings have comprised Arizona's Week of the Young Child celebration, each year centered around a specific theme. Dozens of individuals in Arizona have grouped together to complete the planning and the execution of this celebration. However, the focus has been with the Early Childhood Consultant and the State MCH program. For example, production, assembly and mailing of thousands of packets of information on the Week have been carried out in the offices of the MCH program.

Each year a theme is chosen by the organizers of the week and prominently featured in posters, programs, activity schedules, etc. More importantly, the theme becomes incorporated into the very essence of the lead-up activities, and into the consciousness of the participants and planners.

The theme in 1984 was CHERISH THE WONDERS OF CHILDREN; in 1985 it was VALUE THE DIGNITY OF CHILDREN; and in 1986 it will be SOARING TO NEW HEIGHTS.

The potential for continuing advocacy for better funding and better opportunities for early childhood programs that results from this massive statewide exposure is evident.

PARENT INVOLVEMENT

As the Early Childhood Consultant activity became firmly established within the MCH Program, the Consultant increasingly received requests directly from parents asking assistance in locating a day care center for their child. As these requests increased in number, the consultant found it necessary to develop an elaborate card file in which were listed by geographic location, all of the centers in the state with the center's key characteristics and a description of its program. A large wall map was developed with hundreds of color-coded pins indicating the various categories of centers throughout the state. Familiarity with the programs was only achieved by visits and conversations with center directors and staff. Over the years this system enabled literally thousands of parents to find an appropriate center for their children. In addition, these parent contacts provided a great opportunity to discuss the appropriateness of programs, activities, health care issues, etc. to the developmental level of the child.

As time passed, it became evident to the MCH Director and the Early Childhood Consultant that certain problems recurred in many centers and were the subject of frequent requests for assistance. From this knowledge a series of workshops was planned and conducted for day care operators, staff, com-

munity groups and always. . . parents. Some examples of workshops that were given repeatedly over the years included:

1. Workshops on child abuse. During the 1970's child abuse was becoming widely recognized and a great deal of effort was expended by health and social service agencies to combat the problem. The Day Care Workshops focused on very basic communication skills between parents and their children. They were designed to give day care operators the tools by which they could work directly with individual parents to alleviate stressful situations likely to cause child abuse by a parent.

2. During a time when hepatitis epidemics were occurring in many of Arizona's Day Care Centers, workshops were developed and presented around the state. Personal hygiene, infectious disease control, and sanitation techniques for the center and home were presented. An instructional booklet was designed and distributed to the day care centers to be further distributed to the parents.

3. One of the most popular workshops developed was the activity workshop, affectionately referred to as "Dabble Days." Hundreds of common, everyday materials were collected together and brought to a large meeting place for display and use. One or even two days were devoted to utilization of these materials by parents, Brownie leaders, day care operators, and children who came in, browsed through the various materials, then created projects with paste, paint, cut outs, etc. The workshops were accompanied by explanatory material showing how the activities emphasized creativity and individual expression. "Dabble Days" became a way of teaching child development with a very practical application to the day care setting and in a way which was more like a carnival than a training session.

ADVOCACY

Still another issue extremely pertinent to the Arizona early childhood scene came about in the early 1980's. This was the issue of preschool programs for handicapped children. Arizona lacked authorizing legislation for any such programs extending below the kindergarten age. Almost uniquely among the states, Arizona's legislators were extremely reluctant to involve themselves in this area, to the great concern and frustration of many of the early childhood advocates. The MCH Early Childhood Consultant took the lead, calling together many of the same individuals who had been prominent partners in the MCH program over many years. They formed the Preschool Handicapped Task Force, which in turn mobilized parents and other concerned citizens statewide in an advocacy effort specifically related to the preschool handicapped legislation.

The Consultant became familiar with the legislative process and then, with the aid of coworkers, developed an advocacy packet that was made widely available to any individual who could be identified as having an interest in the subject.

In addition, the advocacy packet was used for related legislative issues such as the development of legislation for a perinatal program and its funding. Whether or not the entire credit can be given to this advocacy effort, it is a fact that the legislature did pass legislation in 1983 which authorized preschool opportunities for handicapped children as well as funding for a perinatal program. Both programs are now well established within the state.

In February, 1986 a renewed advocacy effort in the handicapped area began. The former preschool handicapped task force, now more officially constituted as the special education advisory committee for preschool planning (with a direct tie to the State Department of Education), met and determined that a campaign was needed in 1986. This began with a statewide needs assessment that was carried out regionally by questionnaire, determining in each part of the state whether there were remaining unmet needs for the preschool handicapped youngster. The data so obtained will then be assembled at the state level, and the advisory committee will create a new, updated advocacy packet.

FOLLOW-UP ACTIVITIES

In 1981, the Arizona MCH Program move into the "Modern Era" in its Early Childhood Program was precipitated by a change of personnel in the Early Childhood Consultant position. As frequently occurs when personnel holding major positions are replaced, particularly when the former individual had considerable tenure in the position, new planning and

reassessment of work and work relationships became necessary. This resulted in an exceptionally important structural change in the placement of the position within the MCH Program. Previously the Early Childhood Consultant position had been relatively free-standing, reporting directly to the MCH Director. Concurrently with the personnel change, an organizational change in MCH created a new section on Perinatal Health.

The Early Childhood Consultant was then placed in that section. She thus came into a daily working relationship with individuals whose primary work concern was high risk maternity, and newborn intensive care. The latter program had traditionally included a strong policy of infant follow-up with visits by Public Health Nurses to the homes of all risk infants following their discharge from NICU nurseries. Another major element of the follow-up program was a clinic, especially for high risk infants discharged in the Phoenix area (with a counterpart conducted through the University College of Medicine in Tucson).

The new Early Childhood Consultant was drawn to these aspects of the MCH Program and spent many months of orientation in hospitals, attending clinics, observing the conduct of Brazleton examinations in the intensive care hospitals and learning intimately the work of the Public Health Nurses in the home. The significance of these activities to the larger field of Early Childhood Development was apparent. Increasingly, the Consultant's input became a significant part of planning the activities of the entire section, particularly the segment of infant follow-up.

When very rapid growth of the outpatient prenatal and in-hospital high risk components of perinatal care occurred in 1984 and 1985, the obvious organizational move was to split all follow-up elements off into a new section. With them went early childhood activities. The Early Childhood Consultant became head of this new section, which was called Child Development, and a new employee assumed the Early Childhood Consultant position. The result was consolidation of all planning and supervision of follow-up and early childhood activities under a single individual; more importantly, an individual whose background was not medical/nursing but was early childhood education.

Organizational changes were accompanied by program/location changes. With the move of the entire MCH program from the Children's Hospital to a State Capitol location, it became necessary to find outlying space for the Early Childhood and Infant Follow-up activities. Providing the opportunity to plan and construct an entire new Follow-Up Clinic facility, a suite of offices was leased in a private medical building in central Phoenix. The move also allowed, for the first time, headquartering for the Early Childhood Consultant staff in close proximity to the staff of employees and part-time consultants who are doing clinic follow-up on at-risk infants. The many opportunities for cross referencing of ideas and program elements with this arrangement is obvious.

CHILD DEVELOPMENT SERVICES

Parents of children in day care had virtually minimal exposure to the issue of child development services versus custodial day care. Involvement of parents in programing and in health matters were infrequent.

In addition, a very imaginative new concept for the clinic waiting room was created and is currently in the process of construction. It is called the "DEVELOPMENTAL WAITING ROOM," or "THE FAMILY ROOM." The space for parents and infants waiting for clinic appointments is filled with mock household furnishings, each designed to teach a lesson to both parent and child in the acquisition of normal living skills. The concept of this Developmental Waiting Room was that of the Early Childhood Consultant; the specific development was by an organization called Articipate—Participatory Art & Design Concepts, located in the Phoenix metropolitan area.

Within a year of being assigned to the Perinatal section, the Early Childhood Consultant had conceived and developed (in conjunction with the Nursing Coordinator of the Home Follow-up Program) a series of in-service training programs for community hospitals in the rural areas of the state. The subject was Child Life and Child Development. These two individuals traveled to virtually all of the outlying areas in Arizona, making presentations to public health nurses, community leaders, and many parents on child development, one from the aspect of nursing and medical follow-up, the other from the aspect of early childhood education.

Another result of the amalgamation of these two program areas has been the institution of an expanded home-based parent training program into the follow-up. Previously, the Public Health Nurses entered the home to assess the status of the infant, to determine the need for referral to the Follow-up Clinic, to assist the parent in common care-giving techniques, and to address any specific health problems that the child might have.

This new component brings in the element of introducing the parents to the educational aspects of their child's future. Subjects such as the need for early preschool training because of possible handicapping delays are discussed and thoroughly evaluated. Decisions as to the appropriate placement of the child in a more normal preschool program can be carried out. A wide range of social problems can be anticipated and assistance can be provided to the parents. These developmental phases in the child's care, initially home-based, inevitably lead to considerations of care away from the home and the more traditional area of "Child Day Care." The Arizona program now addresses its child day care concerns from a solid base of experience in the earlier aspects of the child's development beginning in earliest infancy.

RECOMMENDATIONS

It has been the Arizona experience that the addition of an individual with specific training and experience in early childhood education to the State Maternal and Child Health staff will repay benefits, measured in enrichment and improvement of the program, far beyond initial expectations. Accordingly, it is strongly recommended that state programs without such an individual give serious consideration to adding one.

Maintenance of such an individual (or a number of such individuals) within state departments of education will in no way substitute. Although there will unquestionably be benefits to be derived (dependent as always on the capabilities of the individuals so placed, and on the level of support provided to their programs), it is the specific alignment with public health programming and traditional MCH priorities and ways of functioning which is the issue. The MCH Early Childhood Consultant will bring together in the community the education leadership with the health leadership (and in many states where day care is the province of the social services agency, that leadership as well).

Hopefully, MCH programs located in the public health agency still retain the flexibility, freedom, and funding (through the MCH block grant) which makes possible the innovation and responsiveness which has characterized the Arizona model.

Many of the individual activity areas described in this profile might be recommended for consideration by others. More detailed descriptive information can be provided for those who wish to explore them. The principal message, however, is that other states should consider the potential for exploring and subsequently addressing their own unique needs through the mechanism of an enriched perspective, made possible by staff augmentation as described above.

Child day care licensing program in Connecticut

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ABSTRACT

This paper discusses the concerns and issues in assuring health and safety as well as the promotion of child development in day care centers. In Connecticut the State Department of Health Services undertook a licensing program as an effort to assure the quality of care. A detailed outline of that licensing process, its strengths, weaknesses and associated problems is presented herewith and results of the effort are described. The licensing program was the beginning of several innovative approaches to helping fill the gaps in day care service. A recommendation for further improvements concludes the paper.

INTRODUCTION

There is nationwide concern for the growing number of children at risk for child abuse, learning disabilities, and accidents and injuries. Increasing disruptions of family support systems are also contributing to children being at risk for failure in growth and development. Parents, particularly the single parent, are struggling hard to provide care for their children while they work.

Connecticut, a northeastern industrialized state of 5009 square miles and a population of approximately 3.2 million, has 701,000 women in the work force. It is estimated that 22,104 Connecticut children live in a single parent family, most of which are headed by women. While statewide per capita income is relatively high (16,556), women earn 59 cents for every dollar earned by a man. Thus children often live in an impoverished state among affluent adults. According to the 1980 census 12% of Connecticut children lived in poverty. So Connecticut, looking for ways to better serve its 350,000 preschool children, found day care centers to be an ideal place to test new ideas for serving preschoolers.

Connecticut has 169 towns with their own local government system. There are no county governments. Children are served at the state level by a variety of departments such as Health, Education, Income Maintenance, Children and Youth Services, and the like. Therefore the coordination of services for children can sometimes be a task in itself.

Currently there are 52,599 children in group day care homes and day care centers. Approximately 8% of these are under three years of age.

The term "child day care" is a generic one and includes part-day and full-day profit and nonprofit programs for children four weeks through approximately 12 years of age. A child day care center offers or provides a program of supplementary care to more than 12 related or unrelated children outside their own homes on a regular basis for a part of the 24 hours in one or more days in the week. A "group day care home" offers or provides a program of supplementary care to not less than seven or more than 12 related or unrelated children on a regular basis for a part of the 24 hours in one or more days in the week.

The following chart indicates the growth in day care over a 15 year period.

	Year 1970	Year 1985	Percentage Increased
Licensed Day Care Centers	587	1,110	89%
Licensed Capacity	15,615	38,592	147%
Children enrolled in centers— Aggregate number enrolled	21,253	49,955	121%
Programs licensed for children under three years of age	120	268	123%
Licensed Capacity 1/86	—	960	
Full Day Care Centers	149	506	240%

Not only is the number of day care centers increasing, but a greater number of children are spending an increasing number of hours outside the home in day care centers. The number of infant day care centers is also increasing rapidly.

HISTORICAL PERSPECTIVE

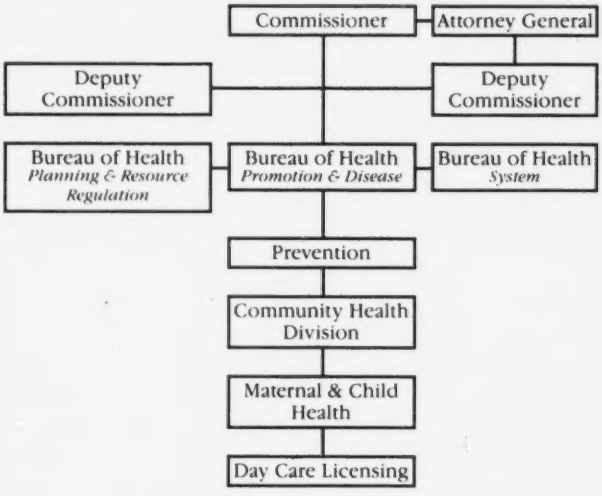
The Department of Health Services is responsible for the licensing of day care centers and group day care homes. This has come about as a result of the Department's long term history of serving children outside their homes.

In 1942, the Department of Health adopted Sanitary Code Regulation 230 for child day care centers to protect the health and safety of children whose families were involved in the war effort. For the next two decades the Deputy Commissioner in the Office of Public Health, in conjunction with local directors of health, issued voluntary certificates of approval to day care centers. The Maternal and Child Health Section staff provided consultation to local directors of health and day care centers, and worked with day care consultants in the State Departments of Education and Welfare on day care standards, health promotion and problem solving.

In fiscal year 1966, there were 500 known day care centers and 346 (or 69%) were certified. As of January 1966, there were 31 child development programs funded by the Office of Economic Opportunity, 11 by the Connecticut Public Act, 523 for Disadvantaged Children and eight funded by Public Law 89-10. In the summer of 1966 an additional 19 towns operated Head Start programs funded by the Office of Economic Opportunity (OEO). Child day care licensing began in 1967. Licensure of child day care centers was mandated by the General Statutes and responsibility given to the Department of Health Services. The protection of the children's health and safety was considered basic. The Department of Health had considerable regulatory experience and the availability of a wide variety of consultants in health and child development to support the licensing. Exemptions from licensing included programs administered by education agencies and recreational and informal, irregular arrangements.

ORGANIZATION

The licensing responsibility within the Department is delegated to the Maternal and Child Health Section because of its expertise in child health, pediatric safety and child development. The section staff includes pediatricians, nurses, social workers and child developmentalists among others. The following chart indicates placement of the day care licensing staff within the Department.



In addition to the expertise of the Section, the day care licensing staff has available the resources of other sections and divisions such as Epidemiology, Health Services for Handicapped Children, Community Nursing and Home Health Care as well as services such as legal counsel to the department. Thus the day care licensing staff is well supported in its endeavor. Because of day care licensing being a substantial regulatory function the Department of Health Services and the Attorney General's staffs' high level of regulatory and enforcement expertise also helps in serving the Department.

Additionally there is an established Child Day Care Council consisting of the Commissioners and delegates from the following state agencies: Health, Children and Youth Services, Income Maintenance, and Education and seven other persons appointed by the Governor respectively representing the Connecticut Association for Education of Young Children, the community council, the community action program, the child development or early childhood education department of a Connecticut college or university, the

provider of child care services, one parent of a child enrolled in tax supported day care, and one parent of a child enrolled in privately supported day care. The council is located within the Department of Human Resources for administrative purposes only. Members serve without compensation. The council offers recommendations to the Commissioner of Health Services regarding regulations and administration affecting child care. Any proposed changes in regulations and other matters of significance are discussed at this council before being acted upon. The council serves to coordinate and unify the efforts of agencies serving preschool children.

STAFFING AT STATE LEVEL

Licensing inspections are carried out by six day care licensing inspectors, all of whom have master's level preparation in early childhood education and child development. Each of the six staff have a designated area of the state for which they are responsible. These inspectors work closely with the staffs of local health departments to license and inspect day care centers. The close relationship between the state and local health departments ensures that local agents are available in all 169 towns to guarantee rapid response and increased monitoring. Local health departments statewide contribute the equivalent of 20 full time professionals for inspecting day care centers. Furthermore, local fire marshals and building and zoning departments are also involved. Police are involved as needed. The State Department of Education also provides regular input to the Department of Health Services staff.

RESOURCES AVAILABLE TO DAY CARE LICENSING STAFF

The licensing staff is supervised by the day care licensing supervisor, an early childhood education specialist. This supervisor assures uniform applicability of regulations statewide and provides support and guidance to the staff. A pediatrician, public health nurse consultant, and social worker also work closely with the licensing staff. The nurse helps implement health care services and provides consultation to nurses working at day care centers, particularly infant and toddler centers. The social worker provides assistance to the staff as well as to day care providers in assessing child abuse, behavioral difficulties and arranging for referrals to community agencies. A pediatrician in Maternal and Child Health provides medical consultation.

Other resources of the department available to day care centers include, but are not limited to, nutrition consultation, vision and hearing screening, lead screening, child development clinic, child health clinic, health education collaborative, health services for handicapped children, maternal infant health protection program and genetic services.

LICENSING

The goal of licensing is to assure the children's health and safety at the day care centers, prevent accidents and injuries, and promote positive growth and development. The goal is to provide a nurturing home-like atmosphere conducive to the optimum functioning of each child. Licensing establishes minimum standards of care which day care centers are encouraged to exceed and never to violate.

There is a concern that when young children are grouped together, creating ideal circumstances for the spread of communicable diseases such as gastroenteritis, meningitis, hepatitis, etc., disease control then becomes the primary function of licensing staff.

The following are the principle activities carried out through licensing:

1. Assuring Health and Safety
   - Assuring entry of the child into the health care system—complete annual physical examination is required.
   - Completing immunization as recommended by AAP
   - Review of health records of children and staff
   - Evaluating menus for nutritional contents
   - Promoting hygienic practices by staff and children
   - Promoting screening procedure to encourage early identification of any deviation such as vision and hearing or developmental disabilities
   - Prompt investigating of disease outbreaks
   - Giving periodic workshops for day care center staff on communicable diseases
   - Implementing annual immunization status survey for centers
   - Assisting day care operators in mainstreaming of technology dependent children and/or children with special needs
2. Sanitation and Environmental Hazard Control
   - Checking of water supplies for purity and safety by state and local health department staff
   - Review of food handling to prevent foodborne illnesses
   - Eliminating other environmental hazards such as lead
   - Promoting a safe environment free of hazards such as uncovered electric outlets, broken play equipment or toxic substances within children's reach
3. Promoting Child Development
   - Review of the practice of developmental principles by day care staff
   - Requiring stated staff-child ratio and preparation and qualification of staff

- Review of program provided to children for content and quality
- Assuring continuous affectionate relationship with care giver by requiring small grouping with consistent main care giver
- Giving workshops for day care staff on child development, child abuse, etc.
- Promoting linkages with community resources

4. Prevention of Child Abuse
   - Evaluating staff qualifications and ratio
   - Investigating complaints
   - Requiring a police check of staff record for criminal activity
   - Providing technical assistance in development of policies and procedures

LICENSING PROCESS

The steps involved in the licensing process include the following:

- Prospective operators call the State Department of Health Services.
- Basic information is provided by the staff (includes regulations, statutes, licensing process description, requirements and responsibilities).
- Initial appointment at potential day care site is made by State and local health department staff and a consultant from the Department of Education to provide details of licensing requirements to the prospective operator.
- Application form is completed by the owner/operator stating compliance with Public Health Code.
- Written approval is obtained from local building, zoning, fire and health departments.
- Inspection form is completed and mailed by local health departments with their recommendation for approval, conditional or otherwise, to the State Department of Health Services.
- A day care licensing specialist from the State makes the final inspection.
- A six-month temporary license is granted. (All new programs are issued a six-month temporary license. This gives the State Department of Health Services staff and educational consultant an opportunity to visit programs in operation, provide technical assistance and assure adequate functioning before a permanent license is issued. Visits are made unannounced. The local health department may make additional interim visits.)
- A second six-month license is issued if there are still areas of non-compliance to be improved (only two six-month licenses can be issued).
- The total process takes four days of work over a period of two months.
- Relicensure applications are automatically sent 90 days in advance and the process is repeated.

In the event that violations of public health code are noted, the following steps are taken:

- If the violation is easily correctable, the operator is notified. A repeat visit is made to assure that the corrections and license are in place.
- If there is no indication of correction a "compliance meeting" with the Maternal & Child Health Section Chief is initiated. All documentation of violations is presented by certified letter to the operator. The operator is asked to present his/her case at the meeting. Agreements reached at the meeting are listed. A time period is specified within which corrections must be made and a written plan of action for the same is requested within two weeks.
- Unannounced visits are made to verify compliance.
- Repeat and serious offenders are asked to come for a hearing and subsequently taken to the court following due process of law.

STRENGTHS OF THE PROGRAM

- All of the department's resources (M.D., nursing, social work, epidemiologist and nutritionist, etc.) are utilized to monitor and strengthen services for children at the day care centers.
- Coordination with the Department of Education, the Department of Children and Youth Services, the Department of Human Resources, and the local departments of health, fire, zoning, and building is achieved and used to carry out licensing activities.
- The staff has opportunity to offer day care operators a variety of services to help them upgrade their program. This softens the "regulatory" image and creates a congenial atmosphere.

PROBLEMS

- Staff shortage at the State level reduces opportunity for "preventive" efforts.
- Uniformity of application, regulations and guidelines needs to be watched contin-

uously. However, ongoing monthly meetings with the day care licensing staff and close supervision by the day care licensing supervisor, including visits to day care centers with each of the staff, is carried out to assure uniform application of the law.

- Promotion of the need for day care subsidy by public and private sector is needed. Currently AAP is taking an active role in support of day care.
- The low pay scale for day care providers causes constant rotation of the staff at day care centers necessitating repeated educational efforts by the State level staff. Efforts to promote the value of ongoing training requirements for day care staff are underway (note: recent revision of Public Health Code).
- Generally poor working conditions at day care centers, (long hours, low pay, no opportunity for upward mobility) cause frequent rotation of staff, resulting in the lack of ongoing care for children.
- The lengthy legal process reduces the ability of the State staff to close a "problem" day care center promptly. However, in serious instances the local health departments issue cease and desist orders promptly.
- Lack of choice of adequate day care service forces working parents (particularly low income and minority parents) to ignore problems at the center. The distance and cost, not the quality of the program, become the basis for choosing a day care center. However, public and parental awareness of good day care is being furthered through educational and media efforts.
- Poor availability of "well qualified, trained nursing consultation" for infant day care centers on a consistent basis allows health problems to be overlooked.
- Lack of a well organized system of communication among health care providers, day care operators and parents results in disorganized care for the child.
- Impending insurance crisis for day care centers is creating anxiety among the providers. Encouragingly, a Governor's task force has been formed to deal with the insurance crisis.
- Child abuse panic nationwide is making it difficult to attract males to day care centers. "Fear of touching" among day care providers is spreading.
- Some operators try to be everything to everyone while cutting corners to help meet expenses.

RESULTS OF DAY CARE LICENSING

- Close to 49,000 children are enrolled in day care facilities licensed by the Connecticut Department of Health Services.
- No major crisis, including fire, drowning, major injuries, deaths or serious epidemics, has been noted at licensed day care centers in the last ten years.
- Annual immunization survey reveals 95.4% of children in day care centers were adequately immunized in 1985.
- Approximately 150-200 complaints are investigated annually.
- Formal agreements are in effect with DCYS and DHR to deal with issues of child abuse.
- An ongoing working relationship exists between state and local health departments.
- 3,100 technical assistant encounters were provided during the past year and 1,100 centers monitored.

PROPOSED ACTIVITIES

In spite of the generally satisfactory results of our efforts, we are concerned about infant and toddler day care centers, especially all-day care centers, because an increasing number of mothers of preschool children are returning to work very soon after delivery. Therefore, more infants are spending longer hours at the centers. Unfortunately, there is a lack of uniform availability of quality nursing services at the infant and toddler day care centers, plus there is a gap in communication among health care providers, day care providers and parents. There are fewer slots available for infants and toddlers compared to the demands and the parents have few choices available for infant care.

Out of these concerns came the idea for a SPRANS grant entitled "Promoting and providing health care to infants and toddlers in the day care center". We are proposing to survey 65 infant day care centers to identify the needs of children, parents and providers in regard to health, safety and child development. We will select 12 centers (representing all socioeconomical, geographic and ethnic populations of the state) to develop pilot models for management of the noted needs and concerns. Training of nurse consultants to day care will be provided along with models of procedures, policies and recommendations. We will assess the effectiveness of these activities by noting the changes in the health outcome of children, e.g. immunization status, numbers of illnesses and accidents, changes in the attitudes and abilities of staff, and development of communication among health care providers, day care staff and parents.

Intended outcomes include better health care and developmental practice for infants and toddlers, a greater understanding of the needs of parents and providers, and increased involvement of health care

providers and parents in assuring comprehensive and ongoing care of children at the centers. We will develop manuals to assist the process. Subjects may include:

a. prevention and handling of commonly noted infectious diseases

b. prevention and handling of child abuse including sexual abuse

c. prevention and handling of accidents and injuries

d. enhancing communication between and assigning responsibilities to parents, day care providers and health care providers.

The process has already begun and results will be available in three years.

REFLECTIONS AND RECOMMENDATIONS

Recently in Connecticut, licensing of day care centers by the DOHS was questioned because the legislature was looking for ways to combine child care services into a single agency. After much debate and discussion it was agreed that the licensing of day care centers and group day care homes should be left in the Department of Health Services. Communities in Connecticut supported the Department of Health Services throughout the process. The experience helped us to clarify the responsibilities of public health agencies toward care of children in day care.

The following are statements of our recommendations:

1. Licensing is an important and valuable avenue to assure basic minimum standards of care at day care centers.

2. The State Department of Health Services has proper expertise and experience to better the care of a growing number of children in day care centers. Whether or not licensing of day care centers is carried out by the Department of Health Services, it is imperative that input by the Department be mandated so as to assure the health, safety and promotion of child development in day care centers.

3. As an increasing number of parents in all socioeconomic groups are struggling to balance parental responsibility, responsibility to their employer and responsibility to other family members, they need to be supported. The public health agency can provide this support by activities such as:

- Providing information to help parents evaluate the quality at day care center
- Increasing parents' awareness of their rights and responsibilities as they relate to the day care center
- Providing mechanisms for parental involvement in assuring quality care for their children

4. The staff at day care centers often work long hours with minimal pay and tremendous responsibilities resulting in rapid turnover and lack of continuity of care for children. Recent child abuse scares and the insurance crisis is adding to the staff's stress. Public health agencies need to:

- Provide and facilitate staff training at day care centers
- Help develop mechanisms and management tools to simplify procedures and improve efficiency
- Provide a model for better communication between parents, staff and health care providers

5. Last, but not least, public health agencies should involve themselves in helping to shape "Pro Family" and "Pro Child" societal policies, e.g.

- Carefully examining new trends such as day care for sick children. Thoughtful recommendations should be made to the policy makers so that sick children will receive care from a competent person familiar to the child
- Promoting policies of parental leave with pay and learning on the job to assure consistent, knowledgeable and caring care giving for infants
- Helping to elevate child care to its proper status by improving qualifications and pay scales of child care workers
- Promoting on-site child care by employers
- Promoting social subsidies for child care as an indication of the acceptance of societal responsibility for child rearing

Safeguarding children in day care—the Kansas experience

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ABSTRACT

This paper profiles the achievements of the Kansas Department of Health and Environment in the regulatory safeguarding of children in out-of-home care.

The components necessary for responsible regulatory administration are discussed. These components include: 1) the statutory base; 2) standard formulation and implementation; and 3) administrative support. Regulations which address prevention of child abuse are cited, as well as recent changes in the statute to strengthen the enforcement authority of the agency.

A description is given of the levels of intervention utilized by the department, with accompanying operational examples.

The paper concludes with a summary statement relative to the department's role in legal intervention, and recommendations to other state health departments for future action in the field of regulatory administration.

DEMOGRAPHICS

Kansas is a rural state which had a population of 2,363,679 in 1980 including 180,877 children under five. An estimated 51% of preschool children have mothers who are employed outside the home, and approximately 42,000 of these children live in single-parent families. Kansas' estimated per capita income in 1984 was $13,311.00 with agriculture, oil and aircraft the major industries. Child Care Licensing is a section of the Bureau of Adult and Child Care Facilities in the Division of Health. The state agency is responsible for the regulatory activities with inspections being delegated to local health departments. The central office professional staff consists of three child development specialists and a social worker, with consultation from other disciplines in the department, (medical, nursing, nutrition, health education and legal). There is a close working relationship with other state agencies, including the Fire Marshal's Office, Department of Social and Rehabilitation services, and the Department of Education. For a table of regulated day care facilities by category, see Table II.

INTRODUCTION

The safeguarding of children in out-of-home care is one of the most pressing social needs of our time. The number of working women with children under six years of age has grown dramatically in the past five years, with an accompanying demand for day care.

As demand exceeds supply, and parents have fewer child care options open to them, child care facilities have less motivation to maintain high standards. It is imperative, therefore, that regulatory agencies have a strong commitment to safeguarding children.

There are three basic ingredients which are the

sine qua non of effective regulatory administration: 1) a statutory base to provide the tools for enforcement; 2) sound standards formulation and implementation; and 3) an administrative authority which supports legal intervention. Kansas is fortunate that all of these ingredients are present in the child care licensing program of the Department of Health and Environment.

The statutory base relates to the authority to license, revoke or deny licenses, to formulate and implement standards, and to impose negative sanctions if unregulated care is provided.

Standards (a term used interchangeably with "regulations") identify the risks to children in out-of-home care and establish the requirements that must be met and maintained by providers if they are to be officially approved to care for children.

Statutes and regulations are of limited value unless the regulatory agency is willing to enforce them. Most state agencies statutorily assigned the child care regulatory responsibility have failed to engage in necessary enforcement action. Kansas, however, has an exemplary record historically in the field of enforcement.

This paper reports on the effectiveness of the Kansas Department of Health and Environment in implementing a strong child care regulatory program, with particular emphasis on legal intervention.

BACKGROUND (PROBLEM IDENTIFICATION)

The roots of public regulation of out-of-home child care run long and deep in Kansas. From 1904 to 1923, the Kansas Board of Health was administered by a far-sighted physician, Dr. Samuel Crumbine. In 1915, he sought legislation which established the Division of Child Hygiene (the forerunner of the department's maternal and child health programs) to focus attention on the developmental and health needs of children. In 1918, disturbed by the reports of abuse and neglect of children in institutions and boarding homes, he charged the director of this new division to study the plight of dependent and neglected children. A blue ribbon committee was recruited which included members of the Boards of Health and Administration and their staffs, agents of the Federal Children's Bureau, college instructors, and others with special interest in children's health and welfare. Every children's institution in Kansas, both public and private, was visited, and many children in boarding homes were interviewed. The most general, but basic, standards were used to assess the level of care: Were the children well fed, adequately clothed and kept clean? Were they kindly treated? Were their health needs met and was a doctor called when they were sick? Were goals set for them with programs designed to meet those goals? From the outset, Dr. Crumbine perceived the total well-being of children, whether in their own homes or in care away from home, as a legitimate public health concern. He addressed the same categories of risk as in today's standards.

TABLE I
RISKS IN DAY CARE FACILITIES*

Physical Plant	**Program**
Fire	Staff/Child Ratio
Play Equipment	Activities/Equipment
Safety	Over Enrollment
Transportation	Qualifications
Sanitation	
Building	
Environment	
Health	**Care**
Health Practices	Discipline
Staff Assessments	Neglect
Child Assessments	Physical Abuse
Immunizations	Sexual Abuse
Nutrition	
Injuries	
Emergency Procedures	

Kansas Department of Health and Environment, 1984.

Crumbine's advisory group report was published in the Kansas State Board of Health Bulletins Nos. 8 and 9, "Child Wards of the State" August-September, 1918. The following excerpts from the report illustrate some of the same risks to children identified in Table I.

Sanitation—"The building is old, without running water, toilet or bathroom facilities and entirely unsuited for the purpose. There were more than 20 children, with sleeping quarters for only half that number. The children were sleeping four or five in one bed."

Fire Safety—"The children, about a dozen of them, including three of the superintendent's own, were found in a dark semi-basement, which was used also as a kitchen and dining room. To reach this room the children must descend a very steep, dark and unsafe stairway and pass through a room which is used as a laundry."

Health—"The home needs to provide individual towels and toothbrushes for the children's bathroom. The teeth of all the children should be examined and necessary dental work undertaken. The health of these children would be greatly improved by a thorough physical examination and corrective treatment. Physical examinations should be extended also to the employees."

Activities/equipment—"There was no playroom in this house, no library, and very few games or toys. The best room in the house—a large south room which would be ideal for a children's playroom—has been reserved for the exclusive use of the board meetings."

Discipline—"The trained investigator found that the children were not whipped but they were deprived of necessary articles of food for petty offenses,

**From a presentation at the 1984 annual meeting of American Public Health Association "Kansas Public Health Intervention to Reduce Risks for Children in Day Care", by Dr. Patricia Schloesser et al.*

made to kneel on cold stone floors or shut in dark closets for misconduct."

The summary of the report includes Dr. Crumbine's challenge to the Kansas legislature:

> "The State of Kansas should make it impossible for any individual or group of individuals to receive children or pregnant women without a proper license, regular inspection, and the same amenability to the law as incorporated hospitals, hotels, eating houses and other public accommodations."

Under the leadership of the Health Department, the Kansas legislature enacted the child care licensing act in 1919 and gave the department the administrative responsibility for implementation.

TOOLS OF ENFORCEMENT(STRENGTHS)

Statutory basis: Early and Late

The 1919 act was comprehensive in its coverage. The statute provided (and still provides) no exemptions except for persons related to the child by blood, marriage or legal adoption. Every type of out-of-home child care was addressed, including care of one or more children under sixteen years of age for the purpose of providing the children with food or lodging or both, children's homes, orphanages, day nurseries, children's institutions, detention homes, and maternity homes/centers. Licensure was required for child placing agencies and any child caring facilities operated by such agencies. The basic tools necessary for safeguarding children in child care facilities were set forth as follows: 1) The provisions under which a license was issued were defined; 2) The facility was required to be maintained "with strict regard to the health, comfort, safety and social welfare of children"; 3) The department was authorized to promulgate regulations to further promote the health, safety, and welfare of the children; 4) The department or its designated agent (primarily a local health department) was to make biannual inspections of the facilities. The inspector was granted the right of access and entry to the premises and the right to examine all records required by the statutes; 5) A fee for license was established; 6) Procedures for renewal, denial, or revocation of licenses were set out; and 7) Unlicensed care was stipulated a misdemeanor punishable by fine.

Over the years the statutes have been amended, usually at the request of the regulatory agency in order to strengthen its enforcement capability. In 1978, the authority to promulgate regulations was expanded to delineate areas of child care to be regulated, closely following the categories of risk illustrated in Dr. Crumbine's report. The department was authorized to write regulations in the following areas: 1) safe adequate physical surroundings; 2) healthful food; 3) supervision and care of children by capable, qualified persons of sufficient number; 4) an adequate program of activities and services; and 5) parent involvement.

The definition of types of care to be licensed was amended in 1978 and again in 1980 to include two new categories: 1) "any . . . institution of a type determined by the Secretary to require regulation under provisions of this act", a definition which quelled any arguments that the statute did not mandate the regulation of family day care homes or preschools; and 2) "day care referral agencies", added as a result of questionable practices by a proprietary referral service. Kansas is the only state to license such agencies. Also, in 1980 the authority to register homes for six or fewer children was adopted and by 1986 there were over 3,500 registered child care providers.

As a result of the increased number of child abuse and sexual abuse reports in 1983/84, the department requested the legislature to address the problem. In response, licensing statute 65-516 was amended to state that no person shall maintain a child care facility if in such facility there resides, works, or volunteers any person who 1) has a felony or misdemeanor conviction for a crime against persons; 2) has a felony conviction involving substance abuse; 3) has been adjudicated a juvenile offender for an act which if committed by an adult would be a crime against persons; 4) has committed an act of physical, mental or emotional abuse or neglect, or sexual abuse as validated by the Department of Social and Rehabilitation Services; 5) has had a child declared to be deprived or in need of care; and 6) has had parental rights severed.

A further amendment to this statute granted the department access to court orders or adjudications of record, criminal history records information in the possession of the Kansas Bureau of Investigation, and protective service investigations in the possession of the Department of Social and Rehabilitation Services concerning persons residing, working or volunteering in child care facilities. During the same legislative session the department was granted authority to suspend a license or registration certificate when the action was necessary to protect any child from physical abandonment or any other substantial threat to health or safety (K.S.A. 65-501 to 65-525, 1986.).

Standards

Although a strong statutory base is essential for responsible regulatory administration, it is of little value without effective standards formulation and implementation.

Standards (regulations) must be objective, clearly stated, and generally reasonable if they are to be respected by the community and achieve the goal of risk reduction. To this end, the Kansas licensing agency has involved providers, consumers, community persons and regulators in the drafting of child care regulations.

Prior to a comprehensive revision of child care center/preschool regulations in 1971, regional committees were established to draft suggested regulations in areas of health, safety, nutrition, staff/child ratios, teacher qualifications, and program. At a two day statewide meeting, the recommendations from the regions were combined into the final set of regulations. Over 250 people participated in the regulation drafting process.

Citizen input was of particular value in the for-

mulation and acceptance of regulations designed to prevent child abuse, including prohibiting corporal punishment, setting staff/child ratios and group size, establishing training requirements for staff, and allowing parental access to child care facilities during the hours of operation.

It should be noted that Kansas has prohibited corporal punishment in child care centers since the first regulations were filed in 1951.

Well-drafted regulations set up community expectations of performance. When a provider fails to meet these community expectations, there is noncompliance with regulations and the regulatory authority must engage in enforcement action.

Administration

For enforcement action to be successful, the following administrative components are essential:

1. A strong commitment of the regulatory agency to legal intervention
2. Centralization of administrative operations
3. Accessible, knowledgeable legal staff
4. Line workers who understand regulatory practice, and who know how to document violations and make complaint investigations
5. Adequate funding

Kansas has an excellent resource of lineworkers. Based on the authority in the statute to designate agents to make licensing inspections, county public health nurses have been the primary licensing inspectors, backed up by sanitarians who assess risks in the physical plant. Because of their training in child growth and development, health care of children, safety, nutrition, and attention to regulatory detail, nurses not only can understand and assess compliance with regulations, but can also offer technical assistance/consultation to providers, thus making the goal of risk reduction more achievable. An additional advantage is their immediate access to facilities, allowing a higher level of overseeing than is possible by state or regional staff.

IMPLEMENTATION AND ACHIEVEMENT

Child Day Care Categories

Currently, Kansas has five major categories of regulated day care: child care centers, preschools, licensed day care homes, group day care homes and registered family day care homes as found in K.A.R. Chapter 28.

The number of day care facilities and the estimated number of children in care on January 30, 1986 are shown in the table below.

Table II

Type of Facility	Number of Facilities	Estimated Number of Children
Child Care Centers	514	20,000 (avg. 40 per center)
Preschools	399	12,000 (avg. 30 full-time equivalent children)
Licensed Day Care Homes	2,081	20,000 (max. 10 children)
Group Day Care Homes	147	1,800 (max. 12 children)
Registered Day Care Homes	3,464	21,000 (avg. 6 children)
Total	6,605	74,800

Legal Intervention

The majority of child care facilities meet the requirements and are issued a license or registration certificate effective for a year. However, from September, 1983 to September, 1985 additional intervention was necessary in 310 facilities, or 5% of the total, either to reduce risks and bring the facility into compliance, or order it to close. Ninety-two of these enforcement actions, or 29.7% were due to child abuse or neglect, sexual abuse or criminal records (see Table III).

Table III

Enforcement Actions—September, 1983 - September, 1986

Type of Facility*	Total Enforcement Action	Child Abuse	Sexual Abuse	Criminal Record	Child Removed By Court Order
Child Care Centers/ Preschools	86	5	0	4	2
Lic. Day Care Homes/Group Day Care Homes	140	18	12	8	10
Registered Homes	83	20	3	5	5
Total	309	43	15	17	17

*Child Care Centers and Preschools were counted together until FY 1985, as were Licensed Day Care Homes and Group Day Care Homes.

The Department engages in several levels of intervention, some of which have been developed by the Department's licensing and legal staffs, and some of which are mandated by the Kansas Administrative Procedures Act which became effective July 1, 1985.

The levels of intervention and operational examples, chosen from cases involving abuse or neglect, are as follows:

Notice of Noncompliance

The first legal intervention, a procedure mandated by the licensing statutes, is the Notice of Noncompliance, in which regulation violations are cited and the applicant/licensee is given five days to correct them or to submit a corrective action plan.

Operational examples: Applicant was using inappropriate methods of discipline (threatening children with a paddle); health certificates and immunization histories were not on file; basement which had not been approved by fire inspector was being used for child care.

Notice of Intent to Deny or Revoke

The second level, required by the Kansas Administrative Procedure Act, is the Notice of Intent to Deny or Revoke. This legal intervention is used when violations addressed by the Notice of Noncompliance are not or cannot be corrected; when child abuse or neglect is validated by the Department of Social and Rehabilitation Services; when a criminal records check reveals a conviction for a crime which prohibits the applicant from being licensed or registered; when a child has been removed by reason of abuse or neglect or parental rights have been severed.

Administrative Hearing

The child care provider is given the right to an Administrative Hearing on the Notice of Intent to Deny or to Revoke. If a hearing is not requested, the file is closed and child care must cease. If a hearing is held, the Department's final action is presented in the Hearing Officer's Report. Child care may continue pending the outcome of the hearing.

Operational example: Staff/child ratio was not maintained; program director was not qualified; maintenance of the building was inadequate; equipment was insufficient for the children; center had history of regulation violations. Administrative hearing was held. Hearing officer found for the Department. Center was taken over by new management, was licensed and has remained in compliance.

Appeal to Higher Court

The provider has the right to appeal the Department's decision to the District Court, the State Supreme Court and United States Supreme Court. Unless a stay of the Department's Order is granted by the District Court, child care must cease during this process.

Operational Example: Day care home license was revoked based on K.S.A. 65-516. The operator's own child had been found to be in need of care due to abuse and neglect and was removed by court order. Hearing Officer found for the department; however, the licensee obtained a Stay and appealed the decision to the district court. It was remanded back for rehearing, based on a change in statutes.

Suspension

As mentioned earlier, in 1985 the Department was given the authority to suspend a license or registration certificate if there is a substantial threat to the health or safety of children. This is an administrative procedure which can be carried out either prior to an Administrative Hearing, with a hearing to be held within 30 days, or after a hearing, as a time-limited negative sanction.

Operational examples: Registrant left two toddlers and an infant unattended in her basement for a period of two and a half hours. Public health licensing nurses obtained assistance of police in gaining entrance to the home to care for the children pending arrival of provider and notification of the parents. Registration certificate was suspended. Registrant agreed to surrender her certificate.

Original District Court Action

Legal intervention may begin at the District Court level under the following circumstances:

1. If child abuse or child sexual abuse is confirmed, charges against the perpetrator may be filed by the district attorney, following which the Department may suspend the license/certificate and delay further administrative intervention pending the Court's decision.

Operational examples: Child abuse charges were filed in district court against provider. License was suspended pending outcome of court decision. Provider was found guilty and sentenced. License was revoked.

2. If care is unregulated, the district attorney is mandated to file charges upon complaint of the Department or its designated agent. A fine of from $5 to $50 a day for each day of unregulated care may be levied by the judge or an injunction may be filed, closing the facility.

Operational example: A church-operated child care center licensed by the department for nine years did not renew its license. At the request of the department, the county attorney filed an injunction action which closed the facility. The church applied for a Stay which was granted, allowing the center to operate pending an appeal of the Injunction. The center agreed not to use corporal punishment while the Stay was in effect. The church's appeal was based on the first amendment and their allegations that: 1) their congregation believed that its religious beliefs required the use of corporal punishment; and 2) a church should not submit to the authority of the state by obtaining a child care license.

The district judge ruled that the church's religious beliefs were not burdened by state regulations prohibiting corporal punishment and that the congregation did not have a genuine religious belief requiring them not to be licensed. The Kansas Supreme Court confirmed the district court and ordered the facility to close. It held that the operation of a day care center was not a religious activity and did not qualify for first amendment protection.[1]

Table IV shows the use of each level of intervention for all areas of noncompliance during FY 1985.

[1] *The State ex rel., William Pringle, County Attorney, Barton County, Kansas, vs. Heritage Baptist Temple, Inc., et al., Supreme Court Syllabus, No. 56, 578.*

TABLE IV

Levels of Intervention for Each Category of Day Care

	Notice of Non-compliance	Denial	Revoc.	Hearing	Suspension**
Child Care Centers/ Preschools	68	11	7	5	1
Licensed Day Care Homes/ Group Day Care Homes	60	39	36	13	2
Registered Day Care Homes	11	24	48	15	2
Totals	139	74	91	33	5

**Three additional suspensions were prepared but not issued due to surrender of license.

Local health department staff are involved in all levels of intervention. They are expected to confirm or refute the claim that corrections have been made following the issuance of a Notice of Noncompliance; they appear as witnesses at administrative and court hearings; and they document unregulated care and file complaints with the county attorney.

EVALUATION

An analysis of legal intervention by the Kansas Department of Health and Environment points out conclusively that given a supportive statute and enforceable regulations, a state/local public health system constitutes a viable structure for safeguarding children. Other conclusions are as follows:

1. That legal intervention in Kansas is comprehensive in nature, including enforcement actions relating to regulatory violations, child abuse, sexual abuse, felonies/misdemeanors, and unregulated private and church-sponsored day care.

2. That legal intervention to prevent child abuse/sexual abuse is dependent upon a legislative mandate to the protective service agency to share protective service investigations with the regulatory authority. Close cooperation between the two agencies is essential to safeguard children against abuse.

3. That in the majority of denial and revocation cases going to an administrative hearing, the department's position has been positively supported by the hearing officer, indicating a high level of responsible enforcement action.

4. That legal intervention is of a significant magnitude to reduce risks to children in day care.

RECOMMENDATIONS

The authors recommend that state health departments assume an active role in the field of day care regulation. Public health departments are particularly well suited to this role because of their interest in prevention, their expertise in the areas of health and safety, and their extensive regulatory experience in other areas.

The paired inspection

A useful tool in building licensor reliability

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ABSTRACT

The Maryland State Department of Health and Mental Hygiene licenses 941 group day care centers using a model which includes centralized direction from the Department and implementation through each of 24 local health departments. Equitable and effective regulation of these centers depends on achieving consistency among those local departments and reliability among those who inspect. This paper explains the process which the Maryland Department of Health has used to address these issues and offers its paired inspection as a model for others.

INTRODUCTION

Maryland has often been referred to as "America in Miniature." The description is apt because the state's geographical characteristics encompass the sands of the Atlantic beaches, the flat farmland of the Eastern shore and the nation's largest inland bay, the Chesapeake. At the bay, great bridges reach across to the deep-water port, tobacco farms, rolling horse country and dairy regions of the Piedmont Plateau, which then rises to meet the heavily forested Appalachian Mountains.

The analogy is also applicable to the varied ways of life represented in the state's quiet farming and fishing villages, bustling oceanside and mountain resorts, row houses clustered in Baltimore's ethnic neighborhoods and the megalopolis which stretches 35 miles from that city to Washington, D.C. In contrast, the quiet colonial city of Annapolis, home of the U.S. Naval Academy, is the capitol.

Politically, Maryland is made up of 24 subdivisions, 23 counties and Baltimore City. Each is administered by an elected representative council and has separate local agencies for health, education and social services. These agencies relate to corresponding state agencies. By law, the local health department is headed by a physician or an administrator with a physician as deputy. The head of the local health department must be approved and appointed by both the local government and the Secretary of the Maryland State Department of Health and Mental Hygiene (DHMH). Local health department activities are funded through a state/federal-local "matching" formula and through direct state grants.[1]

Economically, in 1979 10% of the state's population had income below the poverty level compared to 12% of all U.S. residents. However, median income for families with children under age 18 ran above national averages for that year. When the figures are adjusted to reflect median family income in families with children under age six incomes range from $5,383 for a black, female householder with no husband present to $22,606 for a white, two

[1]*Material in this paragraph contributed by Eric M. Fine, M.D., M.P.H., F.A.A.P., Director, Preventive Medicine Administration, DHMH.*

parent family.[2]

Maryland ranks 42nd in area among the states but ranks 18th in population. In 1982, an estimated 4,270,420 people lived within the state's borders. Population density varies from over 8,000 per square mile in Baltimore City to only 40 per square mile in the western mountainous regions. Approximately 25% of the population is non-white, compared to about 14% nationally. Of the total population, approximately 8% (325,152) are children who are five years old or younger.

In 1980, 47% of mothers with children under age three (65,492 mothers) and 56% of mothers with children aged three through five were in the labor force (51,663 mothers). In addition, 67% of mothers of children six through 14 years old worked outside of the home (399,732 mothers). Today, approximately 80,000 children are being cared for in roughly 6,000 registered family day care homes, 941 licensed group day care centers, and 56 before and after school programs appended to approved non-public schools.[3]

The analogy, "America in Miniature" could also be applied to the way in which Maryland regulates child care, since each of the three primary types is regulated by a separate agency using a different model. This paper presents an overview of the state child care licensing structure as the context from within which the Division of Child Day Care Center Licensing and Consultation Services, DHMH, has approached the vital regulatory problem of ensuring that each facility inspected for compliance with a set of standards be evaluated consistently and accurately. The paper focuses on a paired inspection exercise as part of the effort to achieve licensor reliability among approximately 100 licensing staff in 24 independent political subdivisions.

THE MARYLAND MODEL

Ensuring child care services which promote sound growth and development for children in safe and healthful surroundings is the challenge of each licensing program across this nation. Although laws, the location of licensing in the structure of government, and implementation vary, the underlying theme persists. Each state grapples with how to design regulatory activities so that its child care programs are regulated equitably and effectively.

Each of Three Types of Day Care Licensed by a Separate Agency

In Maryland, the Legislature analyzed the three basic settings for out-of-home, part-time care for children—family day care homes, group day care centers, and pre-schools—to determine how each might be licensed most appropriately. It gave primary responsibility for licensing each type of care to the state agency which it believed to be best suited to address the unique characteristics of the setting.

In this three-agency system, family day care homes (care for six or fewer children in a residence) are registered by the Maryland State Department of Human Resources (DHR). Group day care centers (care for two to six children outside of a residence or seven or more children irrespective of site) are licensed by DHMH.

Non-public nursery schools, kindergartens, and elementary schools (characterized by their instructional emphasis) are approved by the Maryland State Department of Education (MSDE). If an approved school offers before and/or after school child care and that care meets criteria established by MSDE, it, too, is subject to approval by that agency.

There are several situations where two of the three agencies may be involved. First, if a school chooses to offer child care other than that which MSDE approves, that care is subject to DHMH licensure. Another example is that a school operated by a bona fide religious organization may apply to MSDE for exemption of its school day, but any part or full day child care which the religious organization may offer is subject to licensure by DHMH. In another model, a day care center, licensed by DHMH, may seek approval from MSDE for its instructional component.

Finally, both DHR and MSDE look to local health departments to carry out traditional public health functions in the facilities which they regulate.

Staff from the three agencies work together to develop compatibility among the licensing programs and coherence in the overall licensing structure. This coordinating process was formalized and strengthened in July, 1986 through creation of a state-level interagency council to address licensing issues.

The DHMH Group Day Care Center Licensing Model

The group day care center licensing program is administered by the Division of Child Day Care Center Licensing and Consultation Services (Division) in the Preventive Medicine Administration, (PMA), of DHMH. This location is a logical one for carrying out the legislative mandate to identify risks to children receiving care in a group setting and to offset those risks by reasonable protective measures. It is no coincidence that many of those risks are health related and that protective measures are often preventive in nature. Related technical assistance is available in PMA through such programs as communicable disease control, nutrition education, lead screening, and a vast array of infant and child health initiatives.

However, the law's equally strong requirement of strategies to ensure sound growth and development dictated inclusion of that component also. To accommodate that emphasis, the Chief of the Division is drawn from the community of child development professionals. The Division also includes a second Child Development Specialist (CDS), a Nutritionist, a Community Health Nurse, a Licensing Specialist, and

[2]*Median income information in this paragraph from* ***Children, Families and Child Care in Maryland****, published by the Maryland Committee for Children.*

[3]*Statistics in this paragraph from* ***Children, Families and Child Care in Maryland****, published by the Maryland Committee for Children.*

an Administrative Officer.

To provide consultation in areas in which PMA does not have expertise, a State Day Care Unit was created.

Currently, members include a specialist in environmental matters, an Assistant Attorney General, and the State Fire Marshal. Although a representative of the Protective Services staff in DHR is not a formal member of the Unit, the Division and that staff have developed a productive working relationship through struggling together to develop policies and procedures on child abuse in centers.

This structure provides a fertile, supportive environment from which to administer a comprehensive group day care center licensing program.

The actual day to day center licensing activities are carried out by the local health departments in each of Maryland's 23 counties and the Baltimore City Department of Health. This state/local partnership recognizes the values of a uniform law, regulations, and policies[4], and the benefits of centralized direction, training, and overview coupled with the strengths inherent when licensors and licensees are in proximity.

The Local Licensing Team

Each local health department assigns a licensing team which includes a sanitarian, a nurse, a specialist in child development, and a nutritionist (or another team member cross-trained to evaluate the nutrition component of a center's program). Each team member performs inspections, provides technical assistance, facilitates consultation, and responds to complaints related to regulations in his area of professional expertise. In addition, a Licensing Coordinator, who may also do inspections and carry out additional functions in his own professional area, manages the licensing process and monitors the need for negative enforcement activities. The Coordinator is responsible for maintaining communication with licensees, the team, his Health Officer, and the state office, and is the official custodian for licensing records.

Even though team members may work in different units of a local department, the team concept provides a unifying structure which encourages routine communication about common or interrelated concerns, ensures a group with varying perspectives but a common focus for problem solving, and provides a support system for licensors and licensees.

The team concept acknowledges the importance of each aspect of the regulations and offers a unique mechanism to coordinate health, environmental, and programmatic issues. Through this approach, a center may be viewed as a whole and its children have the opportunity to benefit from a comprehensive licensing program designed to ensure their sound physical, emotional, social and intellectual development.

[4]*Although Baltimore City and several home rule counties have their own day nursery laws, all are compatible with the state law. Baltimore City is the only jurisdiction to promulgate its own comprehensive regulations. Those regulations and the City's administrative policies are essentially parallel to those in place throughout the rest of Maryland.*

A VITAL OPERATIONAL PROBLEM: UNIFORMITY

In this licensing model of centralized administration and local implementation with no direct supervisory links, a vital operational problem is ensuring that regulations and licensing procedures are applied uniformly and accurately statewide.

This problem was articulated in 1979 by Mary Jane Edlund, then Chief of the Division. In "The Team Concept in Child Day Care Licensing in Maryland," a "Paper of Significance" published in the April, 1980 ARA Newsletter, Edlund wrote, "Maryland's experience is one of adaptation to a State and local system in which local autonomy demands respect and one in which uniformity is not easily achieved."

John and Karen Lounsbury with Ted Brown addressed this issue in their studies in the mid-1970's. In a paper summarizing their research, published in the Winter 1976 issue of *Child Care Quarterly*, they presented their rationale:

> An effective state day care licensing system should be capable of administering all day care standards in a uniform manner. Thus, standards should be applied uniformly across the state, consistently between different licensing staff, and consistently by the same person over time. The term "standards" itself implies a set of criteria applied uniformly. If standards are not uniformly applied, even the most stringent and comprehensive standards may not ensure adequate safeguarding of children. Non-uniform application of standards may have the effect of denying "equal protection" to

day care operators if some are treated more severely than others by the idiosyncratic interpretations of their licensing representatives. In addition, uniformity of standards provides assurance to parents of day care children that licensed facilities throughout the state attain the same minimum levels of protection and care.

Norris Class uses the term, "reliability" to label this concept. In his paper, "A Policy Planning Paper on Assuming a Regulatory Stance in Child Care Licensing," presented at the Virginia Commonwealth University Institute on Licensing in October, 1981, he lists "zealous commitment to reliability in compliance determination" as one of four "requisites for valid implementation of a regulatory stance in licensing administration." He defines reliability as "arriving at the same finding (determination) regardless of who makes the investigation and for pretty much the same reasons."

Maryland's goal of reliability expands on this definition by stating that which is implied: licensors should arrive at the same findings for the same reasons and should also arrive at a finding which is consistent with the stated standard.

Maryland's commitment to achieving reliability can be identified in promulgation of comprehensive statewide regulations in 1971, construction of licensing forms to standardize documentation of inspection findings, commitment to staff development activities, and publication of the *Manual for Regulations and Licensing Procedures for Group Day Care Centers in Maryland*.

The value of the process of developing the Manual cannot be overstated. The rounds of discussion, drafts, comment periods, and revisions identified differences in application of the regulations and developed a consensus of how to evaluate for compliance with each regulation. In its final form, the Manual furnished each licensor and each licensee with the statement of intent for each regulation, procedures and standards for evaluating each regulation, and a guide to conducting inspections. In short, the Manual provided a standard for assessing reliability.

THE CONCEPT OF PAIRED INSPECTIONS DEVELOPS

Joint state/local inspections to assess reliability of regulations application were first considered in 1977. That year, the Division initiated a biennial Procedure for evaluating local licensing programs. That Procedure was patterned after public health restaurant surveys which included paired inspections. The paired component was not transferred to the Procedure at that time; however, the concept was noted.

Early in 1979, motivated by the Lounsbury "Paired-Observers" study, the theme was picked up again. The Division Chief and the Child Development Specialist conducted inspections together to evaluate their mutual reliability but did not include a paired component in that year's procedure. However, the report from the 1979 Procedure nourished the concept.

In that report, a comparison of the 1977 Procedure findings and the 1979 Procedure findings suggested that centers were demonstrating vastly improved rates of compliance with the regulations. However, Mrs. Edlund, who wrote the report, concluded that she could not express confidence in the stated frequency and patterns of violations without also knowing that the reliability of the persons who did the inspections had been established.

In the summer of 1980, it became apparent that the growing concern to measure reliability, publication of the Manual, and the 1981 Procedure would merge nicely. The challenge to assess reliability was clear in the 1979 Procedure. The Manual, which was in final draft form, provided support in making a fresh start to jurisdictions and inspectors who may have been applying regulations or carrying out procedures idiosyncratically.

It was in this climate that Maryland added a paired inspection to the 1981 Procedure.

THE PAIRED INSPECTION

Preliminary Activities

Once committed, it was necessary to approach three preliminary activities simultaneously so that the Procedure could begin as scheduled in the Spring of 1981. Those preliminary activities were:

1. Establishing the reliability of the two state staff surveyors (the Chief of the Division and the Child Development Specialist) who would conduct the paired inspections
2. Preparing local licensors for the exercise
3. Designing the exercise

The two surveyors, accompanied by a representative of the cooperating local health department, did inspections together until they were able to document that they agreed consistently with each other and with the Manual as to what constituted compliance with or violation of each regulation assessed by a Child Development Specialist.

As the design took form, information was shared with Licensing Coordinators and Child Development Specialists in local health departments. Their feedback was helpful in identifying potential problems and deciding how they would be resolved. This exchange also permitted expression of the anxieties aroused by moving from a Procedure relying almost entirely on reviewing files to one including the more personal element of an assessment of an actual inspection. Given the local/state relationship, the paired component was dependent on cooperation from each local department. By early fall of 1980, each jurisdiction had indicated its willingness to participate.

In November, 1980, a letter was sent to local health departments formally announcing the paired child development inspection as part of the 1981 Procedure. The letter outlined the Division's goal of ensur-

ing that regulations and licensing procedures be applied uniformly and accurately statewide; explained how reliability had been achieved by the surveyors; named the center randomly selected for the inspection; asked the inspector who would routinely conduct that inspection to schedule the inspection with the state surveyor and to prepare the licensee for the exercise; provided information about how the exercise would be conducted and evaluated; and concluded by offering to answer individual questions.

The Process

In each county and in Baltimore City, a surveyor accompanied the inspector doing the child development component of the regular relicensing inspection. Each individual completed the inspection in the company of the other but independently. However, the surveyor did not interview.

The surveyor also used the Paired Inspection Score Sheet to note when the inspector demonstrated any of the 15 desireable licensing procedures recommended in the "Guide for Use of Day Care Center Inspection Forms," developed as part of the Manual.

After leaving the center, the surveyor shared perceptions about whether the inspector had demonstrated the desired procedures or, in the case of the first and second activities, had indicated the desired action in casual but directed conversation on the way to the inspection site. One point was credited for each of the 15 procedures demonstrated.

Then the surveyor and the inspector compared findings on the inspection itself and discussed differences to ascertain whether the inspector had evaluated compliance with each regulation as stated in the Code of Maryland Regulations 10.05.01, Group Day Care Centers, and the corresponding guides for inspection in the Manual. One negative point was recorded for each violation cited by the inspector which in fact did not exist and for each violation which did exist and was not cited.

Reliability of Findings

The paired inspection is a tool which provides clues as to how reliably regulations and licensing procedures are being applied and identifies areas where training is indicated to increase that likelihood. It is inappropriate, however, to draw sweeping generalizations from the findings of this exercise for the following reasons:

1. This exercise included only one inspection in each jurisdiction. To ensure statistical reliability of at least 90%, paired inspections should have been conducted in approximately 10% of the centers in each jurisdiction. Differences in findings tend to develop in marginal situations so, to be truly representative, the number of inspections should have been greater.

2. In four of the 24 jurisdictions (those included in the Baltimore-Washington corridor), more than one person did child development inspections. For purposes of this exercise it was assumed, but not verified, that inspectors within jurisdictions were standardized.

3. In two counties, the surveyor identified problems which put the children in the center at serious risk. When these problems went unacknowledged by the inspector, the surveyor "broke silence" and moved into a support role with the inspector so that the problems could be addressed with the licensee. It cannot be known how the inspector would have evaluated the center in a pure exercise.

4. Even though the reliability of the two surveyors had been established, the fact that the Division Chief participated in three of the inspections while the Child Development Specialist did the other 21 did not allow for an even distribution of their potential variations in the statistics.

5. Three Child Development Specialists work in more than one county each, therefore, the 24 inspections were done by only 14 different licensors. The alternatives of each CDS with multi-county areas doing a single inspection with the score being generalized to the other county or counties assigned or, doing one inspection in each county to establish an independent score for the county were weighed. The latter option was chosen but feedback was delayed for those inspections until the inspector had completed the assigned counties series. It cannot be known how that decision influenced the findings.

RESULTS OF THE PAIRED INSPECTION EXERCISE

Inspection Procedures

The 15 inspection procedures were chosen because each is a component of positive licensing technique. Each contributes to the orderly flow of the process or demonstrates that the process is open for

the licensee to observe or fortifies the concept that the process is fair and reasonable. Each contributes toward building trust in and respect for inspectors and regulatory activities.

The inspection procedures scores, by jurisdiction, ranged from 12 (80%) to 15 (100%). Of the 24 jurisdictions, nine or 37.5% demonstrated 100% of the procedures; seven or 29% demonstrated 93% of the procedures; four or 16.75% demonstrated 86% of the procedures; and four or 16.75% demonstrated 80% of the procedures. The average score by jurisdiction was 13.875 or 93%.

Of the 27 instances when a desirable inspection procedure was not demonstrated, 21 or 78% were in three categories:

1. #11—Asking the person interviewed if he wanted to have the inspection findings reviewed—accounted for six or 22% of the "No's" recorded.

2. #12—Explaining the function of the signature of the person interviewed to that person—accounted for eight or 30% of the "No's" recorded.

3. #13—Telling the person interviewed how he might indicate disagreement with the findings—accounted for seven or 26% of the "No's" recorded.

When scores were computed for each of the 14 inspectors, the average score was 13.2 or 88%.

Child Development Findings

The primary purpose for doing the paired child development inspection was to begin to assess how accurately those regulations were being applied across the state.

It must be noted, however, that compliance or non-compliance with many regulations is obvious. Little likelihood of disagreement exists over whether a license is posted or whether the number of children present exceeds the licensed capacity of the center. The fact that compliance or non-compliance with many regulations is generally self evident ensures a high degree of reliability. In most cases, licensees know precisely what they need to do to comply and inspectors know precisely what constitutes compliance. "Gray" areas exist around judgmental application of regulations such as those pertaining to "adequate" materials or "appropriate" activities.

Each inspection required evaluating for compliance on 67 items. The scores by jurisdiction ranged from -5 (93%) to -0 (100%). The average error rate was -1.5 indicating statewide accuracy of application of child development regulations of 98%. Cumulatively all inspectors cited violations which did not exist or failed to cite violations which did exist a total of 36 times. Of those 36 inaccurate determinations, 24 or 67% were essentially judgmental.

The other 12 or 33% occurred when one person observed or failed to observe a fact upon which the other person's decision was based.

Further analysis indicated that in 12 or 33% of the 36 cases, inspectors cited violations when the licensee had met the requirements of the regulation. One inspector cited a violation for a center having a generous quantity and variety of dramatic play props for not having male dress-ups when dress-ups, as such, are not required. Another cited a violation because the home living area equipment was metal rather than the more traditional wood. In the remaining 24 or 67% of the cases, the inspector indicated compliance where a violation existed. Examples included approving oversized groups and approving staff records without all the required components being present.

The 36 inaccurate determinations were limited to 23 or 34% of the 67 items. Of the 23, 10 were assessed incorrectly two or more times.

Cumulative Scores

The paired inspection process addressed both the reliability of the findings on the child development inspection and the inspectors' demonstration of specific positive licensing procedures. The cumulative scores included both components.

Overall cumulative scores by jurisdiction ranged from eight or 53% to 15 or 100% for an average reliability rate of 12.375 or 82.5%. By inspector, the average score was 11.27 for a reliability rate of 75%.

Looking for Patterns

Even though the data was much too slim to be generalized, it was analyzed for patterns which might link an inspector's education, training, or experience to that inspector's score on the paired inspection.

The only clear pattern that emerged was that each of the seven scores of 15 (100%) was earned by an inspector who did a series of paired inspections and after the first inspection.

EVALUATION

This is a simple, beginning step in the area of paired inspections. Given all the factors which could have distorted the findings, it is inappropriate to proclaim the high degree of reliability suggested by some of the statistics, but there were some specific benefits from the experience.

1. Through developing and carrying out the exercise, statewide attention was focused on the issues of equal treatment and uniform practice. Licensors plainly showed a growing commitment to building reliability through consistent and accurate application of procedures and regulations.

2. The findings on the licensing procedures component indicated specific areas in which to concentrate efforts to encourage inspectors to practice procedures that reinforce safeguards for licensees.

3. The child development inspection findings targeted training needs, but also isolated sections of the regulations which are vaguely written. Even with the standardization offered by the Manual, there were several instances when the inspector and the surveyor disagreed about a finding and could not reconcile that disagreement. Those disagreements clustered around three regulations:

a) Playground (What satisfies the requirement "appropriately equipped"?)

b) Group Size and Staffing (How should ratios be applied during naptime?)

c) Dramatic Play Equipment (Specifically what could inspectors require?)

After the entire series of paired inspections was completed, the child development inspectors resolved these issues themselves pending clarification in the regulations.

4. The paired inspection exercise provided direction for subsequent standardization activities. The next steps were clear:

a) Continue to offer group and individual training for inspectors

b) Encourage all jurisdictions to participate in training activities

c) Expand the format of the paired inspection as a training tool

d) Improve the regulations and Manual to be more precise

e) Redesign the exercise to ensure greater reliability

f) Expand the scope of the exercise to include health, nutrition, and environmental inspectors

g) Repeat the exercise with child development inspectors

Some Thoughts to Ponder

As the person with primary responsibility for this exercise and as the principle surveyor, I had opportunity to observe and consider the dynamics of many different individual styles. I noted the contrast between inspectors who moved methodically from point to point on the inspection sheet and others who observed overall and then looked for a place to cite problems. Some inspectors seemed to have pre-picked issues while others had a broader focus. The hypothesis that expectations influence findings began to develop when my notes revealed that an inspector who had characterized a center as being a "good" one often missed deficiencies obvious to me; and an inspector who had characterized a center as being "troublesome" tended to cite violations where there were none. These are behaviors which warrant additional thought and study as we work to perfect regulatory practice.

But, most importantly, by working with an inspector in each jurisdiction of Maryland, I was privy to a priceless pool of cumulative knowledge, skill, and experience which could be integrated into our ongoing program to build an efficient, effective licensing program.

RECOMMENDATIONS

The paired inspection has demonstrated its value as an evaluative tool in both the Lounsbury study and the Maryland exercise. With a different emphasis, the process could be diagnostic. By adding feedback from surveyor to inspector, the paired inspection becomes a training tool. Since the issue of consistent findings is, or should be, of concern in any program relying on inspections to confirm compliance, the paired inspection should be considered as a tool to build licensor reliability.

Paired Inspection Score Sheet

Yes No

I. Inspection Procedures

Did you

1. wait for the licensing coordinator's cue before conducting this inspection?
2. review the file before making this inspection?
3. inform the person interviewed of who you are?
4. inform the person interviewed of why you are there?
5. invite the senior person at the center to accompany you during the inspection?
6. jointly, with the center representative, determine attendance by actual head count?
7. give the person interviewed the opportunity to show that the violation might not exist before citing the violation?
8. "teach to" or reinforce at least one regulation?
9. discuss each violation cited and explore alternatives for coming into compliance?
10. limit discussion items (D's) to regulations where compliance cannot be observed?
11. ask if the person interviewed wished to have the findings reviewed?
12. explain the function of the signature of the person interviewed?
13. tell the person interviewed how he might indicate disagreement with the findings?
14. sign the report?
15. leave the carbon copy of the report with the person interviewed?

Total

II. Violations Cited Which Do Not Exist and Violations Not Cited Which Do Exist

Number Regulation

Total

Score Part I

Part II

Net Score

The Massachusetts Preschool Health Program: an initiative in collaboration

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ABSTRACT

The Massachusetts initiative for health in day care illustrates the efforts of an MCH/CC Agency which does not have regulatory authority for day care. Over a period of only a few years, the MCH/CC Agency has established a viable Preschool Health Program in cooperation and collaboration with other staff within the Department, other state agencies, and community organizations. The Program has provided needs assessment, training opportunities, technical assistance, a federally funded family day care project, and assistance in day care health standard setting. The MCH/CC Agency has been an active catalyst in focusing attention on the issues of health in day care and has succeeded in establishing MCH/CC as a prominent day care agency without changes in legislative mandates.

From the beginning, intra-agency and inter-agency coordination and collaboration were priority goals. Two working groups were convened—one for projects within the division and another with the key state agencies identified through the interview process. The initial goals of the initiative were: 1) to educate one another about the health-related preschool activities which were taking place; 2) to conduct a local needs assessment to identify health services in day care centers and gaps in services; 3) to collaborate within the Department of Public Health and with other state agencies to increase the amount and quality of day care health training and technical assistance for day care settings.

As a result of the needs assessment process, the Preschool Health Program began to plan activities on several fronts: 1) development of a comprehensive Health in Day Care guide for day care providers; 2) establishing a plan for presenting statewide training conferences and workshops; and 3) participation in several day care interagency task forces and working groups to influence policy development and standard setting.

Due to the lack of program staff and training funds, the Preschool Health Program has been forced to assume the role of coordinator and facilitator. The program functions as a catalyst to others to see that the task of improving health in day care is addressed. This has become a productive role to foster interagency investment in day care health promotion. The recent involvement of the Department of Public Health as an integral state agency in day care policy and services has been the result of establishing a presence of health as a prominent day care issue. This recognition has occurred as an outgrowth of activities such as affiliations with other agencies and professional associations, public notice at conferences and in local publications, participation on relevant task forces, and development of a federal family day care project in response to expressed needs.

With neither direct regulatory authority nor a specific budgetary allocation, what are the roles which a MCH agency can play? The following paper describes how one state MCH agency has developed an innovative and active set of programs in this situa-

tion and how these activities have been integrated into MCH/CC programs.

INTRODUCTION

The development of day care services and problems for young children in Massachusetts reflects the major demographic and social shifts in our nation over the last two decades: increasing numbers of women in the workforce, rising rates of divorce and female-headed households, and the feminization of poverty.

According to the 1980 Census, out of a total population of 5,737,037, there are 337,215 children in Massachusetts aged birth to five years. Forty-three percent of the workforce consists of women with children under the age of six.

One out of every six families (16%) are female-headed households. Of those female-headed households with children under six, 66% live below the poverty line.

In Massachusetts, there is a rapidly expanding day care community. Currently, there are approximately 1,850 licensed group day care centers with an estimated enrollment of 87,000 children and approximately 9,460 registered family day care homes with a capacity of over 40,000 slots available. These numbers reflect a nine percent growth in the most recent year—1985. Even so, demand for day care far exceeds the current supply.

In Massachusetts, both group and family day care are regulated and licensed by the Office for Children, a state agency formed in 1972 to serve both regulatory and advocacy functions. Group day care centers are licensed every two years. At present, family day care homes (defined as having one to six children in care) are registered every two years by filing a self-evaluation questionnaire; homes are not routinely inspected except upon complaint. The Department of Public Health licensed day care programs in Massachusetts prior to the creation of the Office for Children. Since then, the Department has had little systematic or child-focused role in day care, although many of its regulations (such as the Sanitary Code, food service regulations and immunization laws) are incorporated into day care regulations.

In Massachusetts, the day care system is subsidized by state funds from the Department of Social Services (DSS), the state agency responsible for child protection and support services to families and children. Approximately 16,900 slots are purchased by DSS for basic and supportive service care. Additionally, approximately 5,300 child care vouchers are provided by the Departments of Social Services and Public Welfare to support the state's Employment and Training participants.

It was recently estimated that there is a need for six times as many work-related slots as are available through state-funded subsidized slots.

As organized preschool settings begin to replace the public schools as the earliest site at which public health interventions can reach large numbers of children, the opportunities for promoting positive child health and development during the preschool years has grown. Concerns about the adverse health risks of day care have also arisen, from increased spread of some infectious diseases—especially among young children in diapers—to the dangers of abuse or neglect and "custodial" care.

STEPS OF IMPLEMENTATION/ PROBLEM IDENTIFICATION

MCH Programs Related to Day Care

The Division of Family Health Services is the MCH/CC agency for Massachusetts. Since the early 1970s the Division of Family Health Services has not related directly to the day care community, with the exception of funding one model program, the Preschool Enrichment Team. For the last decade, the Preschool team, a multi-disciplinary preventive child health team, has offered on-site consultation to 40 day care centers; vision and hearing screenings and training on screening techniques; child developmental assessments; workshops on issues in child growth; first-aid training; and other services. Even with six full-time equivalent staff, the requests for information, training, and assessments continue to outstrip their capacity.

During this time, the MCH/CC Agency also has supported a number of projects which focused at least some of their activities on the preschool population. Some key programs are listed as examples of MCH involvement with this age group.

> Statewide Childhood Injury Prevention Program (SCIPP)—SCIPP has assembled a number of resource materials, curricula, and training approaches of relevance to day care. In particular, the Home Injury Prevention Project (HIPP) home safety protocol can be adapted for family day care needs. Between 1980 and 1982, this project conducted more than 350 home visits to assess hazards and collected data on more than 60 potentially hazardous items. It also offered active counseling to residents and installed and distributed home safety devices. An evaluation of HIPP indicated it has been successful in reducing the number of hazards in the home. With a special federal grant, SCIPP is currently developing a new training module, "Safe Day Care."
>
> Massachusetts Passenger Safety Program (MPSP)—With funding from the National Highway Traffic Safety Administration, MPSP has developed and coordinated training curricula and resource materials on proper car restraints for preschool children, including speakers' bureaus, safety councils, an industry cost reduction program (e.g., department store car seat discounts), community public safety initiatives, and a car seat loan program.

Massachusetts Childhood Lead Poisoning Prevention Program (CLPPP)—Since 1972, CLPPP has administered a comprehensive state lead law and regulations, including direct services and local projects. Although day care centers must be inspected by regulation and certified in compliance, family day care homes are not routinely inspected. Since 1981, the Division, through the MCH Block Grant, has supported a continuation and expansion of local lead poisoning prevention programs previously funded categorically. Nurses in the Department's regional offices offer lead screening, case management, and outreach to the community to prevent lead poisoning.

In addition, the Department provides many other MCH/CC (including early intervention, WIC, and primary care) and related services (dental health, communicable diseases, and local health services) which can be made available to day care. There are also a number of related programs within the MCH/CC Agency which serve preschool aged children with special needs—early intervention, developmental day care, integrated preschools, etc.

Development of the Preschool Health Program

In the early 80s, MCH began to re-examine its role of serving the general population of preschool children. Since over 125,000 preschool children receive child care within an identifiable and organized day care system, the day care community was determined to be the best target group for activities. Emphasis was placed on child health and development, with a focus on preventive health promotion including injury prevention and communicable diseases, and on early referral to appropriate MCH services.

In order to plan greater involvement with the day care community, MCH conducted key informant interviews in 1983 with other appropriate agencies: the Office for Children, the Department of Social Services, the Department of Education, the Preschool Enrichment Team, and an established child care resource and referral agency. Both the child care providers and other state agencies expressed keen interest in health. Federal funds within the Division were identified in September 1983 to hire a half-time consultant to coordinate the new Preschool Health initiative. The coordinator came directly from preschool day care experience with education/child development background.

From the beginning, intra-agency and inter-agency coordination and collaboration were priority goals. Two working groups were convened—one for projects within the Division and another with the key state agencies identified through the interview process. The initial goals of the initiative were: 1) to educate one another about the health-related preschool activities which were taking place; 2) to conduct a local needs assessment to identify health services in day care centers and gaps in services; 3) to collaborate within the Department of Public Health and with other state agencies to increase the amount and quality of day care health training and technical assistance for day care settings.

Needs Assessment

In December 1983, a comprehensive needs assessment was sent to all licensed day care centers in Boston and Springfield (N = 186). The survey revealed an unexpected degree of interest in providing more health services and receiving health training. Topics most desired for staff training were identifying child abuse and neglect, working with parents, observing and recording child behaviors, identifying common illnesses, use of screening tests, and first aid. Technical assistance was requested by 76.5% on promoting positive child health routines, 73.5% on promoting child safety, and 72.7% on using community health resources. Development of sick child policies and revision of health policies were of least interest, but were still requested by 41% of respondents.

During an additional follow-up telephone survey of all infant/toddler programs in Boston (N = 32), 94% indicated that communicable diseases were their major health concern. Written technical assistance materials and health training, particularly related to issues of communicable diseases, were requested by 76% of the programs. As a result of the needs assessment process, the Preschool Health Program began to plan activities on several fronts: 1) development of a comprehensive *Health in Day Care* guide for day care providers; 2) establishing a plan for presenting statewide training conferences and workshops; and 3) participation in several day care interagency task forces and working groups to influence policy development and standard setting.

Day Care Policy at the State Level

At the same time that DFHS was re-assessing its role with day care, the state was undertaking a similar effort. The demand for child care was growing at a very rapid rate, and it was widely recognized that day care suffered from an uncoordinated state approach. Thus, in March 1984, Governor Michael Dukakis convened the Governor's Day Care Partnership Project to recommend comprehensive strategies to manage and improve day care in Massachusetts. Task force members from state agencies, higher education institutions, private industry, and representative provider and advocacy associations charted a new course. A representative from the Department of Public Health was not invited to become a member, and although training and support was one of the cornerstones of the recommendations, the word "health" never appeared in the report except for one reference to early intervention.

Despite a lack of involvement with the Governor's Partnership report, as the Department of Public Health was becoming more prominent in its role with day care, the director of the new Preschool Health Program was invited to become a member of several other major state task forces related to day care. As chairperson of a health subcommittee of the "Citizen Involvement in Day Care Quality" Committee, she facilitated unanimously accepted changes in the health standards

for state-contracted day care programs. As a member of four other interagency task groups, the director is able to communicate health-related concerns and resources to the group and to report back to Department staff the priorities and needs of the day care community. Currently, these major task forces are actively addressing issues of family day regulations, statewide access to day care training, resource development, the role of child care resource and referral agencies, implementation of early childhood programs within the public schools, and comprehensive planning for special needs children birth to six years of age and their families. Health has become an integral component in each of these efforts.

Through increased opportunities to work more closely with other state agencies and day care providers, it became apparent that family day care providers were an isolated group and were being poorly served in relation to the magnitude of their needs. Thus, the Preschool Health Program developed a proposal for the "Family Day Care Health Project." This project received federal MCH funding as of October 1, 1985; it is founded on a community collaboration and "training of trainers" model, and will serve to strengthen and support technical assistance and training efforts for family day care providers within the central region of Massachusetts. The data gathered by the evaluation component of Family Day Care Health Project will be used directly in setting state family day care regulations and administrative policy.

STRENGTHS

The strength and the relatively rapid development of the Preschool Health Program has been due to interagency cooperation and collaboration. The MCH/CC Agency has health expertise and a commitment to serve the day care community yet no administrative or financial clout. Other agencies may have either authority, purchasing power, or training funds but no health expertise. Our mutual needs have served to bolster productive and cooperative working relationships.

Building Upon MCH Agency Functions

The Preschool Health Program, like all MCH agencies and programs, has four major functions:

- information and research
- standard setting
- technical assistance
- provision of services

Building the Preschool Health Program into these existing agency functions has enabled the Program to expand as an integral part of the agency, rather than an isolated or separate initiative.

> 1) Information and Research: To provide accurate information to the public, professionals, and policy makers on the health status of women and children; and to carry out research on various needs and problems of the population as well as the effectiveness of programs.

The Preschool Health Program was initiated through a needs assessment process. The survey of day care center directors in two large cities of Massachusetts provided the data necessary to chart the future direction of the program. This research effort is replicable in other states, and in fact has been adapted for use in at least two other states.

The Family Day Care Health Project has a research component which will monitor the integration of health and safety practices into the operation of family day care homes and assess the reduction of health risks in family day care settings. The evaluation methodology includes both process and outcome components; it will assess such things as the number of providers reached through training programs or onsite visits; improvements in the health records and increases in preventive health activities and home safety measures after intervention; utilization of a telephone health consultation service; and changes in family day care training and information networks at the community health level.

> 2) Standard setting: To use regulations, guidelines, and other mechanisms to set the highest standards of care.

While the MCH Agency does not regulate day care, there is a clear role for providing input into the development of day care regulations and standards. Other divisions within the Department, such as Food and Drug, Sanitation, and Communicable Diseases, do issue, monitor and enforce a variety of laws, regulations, and codes which affect day care. Some of these are incorporated directly or by reference into day care licensing regulations. Therefore, one standard-setting role for the MCH agency is to participate in and comment on the development of these "core" regulations and codes.

It is already apparent that efforts such as the manual Health in Day Care and the results of the Family Day Care Health Project will have a direct impact on both revised day care regulations and Office for Children's administrative policies. These manual guidelines, while not enforceable as regulations, are the most recent written recommendations that the Massachusetts Department of Public Health has developed for day care. The guidelines were established with the input of other divisions within the Department of Public Health—Communicable Disease Control, Dental, Sanitation, etc.—as well as other state agencies and reviewers from the day care and medical communities.

Participation on a number of day care task forces has clearly influenced the standard setting of those groups. For example, due to participation on the Citizen Involvement in Day Care Quality Committee, state contracted programs are mandated to insure that all children are screened for lead poisoning. Other new standards include sanitation procedures for centers, daily logs for injuries and health concerns, and policies specifying attendance of sick children.

Another example is the effort of the Division to

respond to the issue of AIDS. An MCH pediatrician has closely monitored the state's preschool AIDS policy and has worked with the Department of Public Health's AIDS Coordinator to present forums on the policy for day care staff throughout the state.

> 3) Technical Assistance: To employ professionals who are experts and can provide community programs with expert advice and assistance.

Within six months of the Preschool Health Program's inception, it co-sponsored with Wheelock College a full day preschool health conference for Head Start and day care providers. The Preschool Health Program provided planning, coordination, and almost all of the faculty for the workshops, but none of the other conference expenses. The conference was such a success that this same model was replicated seven months later; the Department of Social Services used its own training funds to sponsor full-day conferences in two areas of the state. The conference included workshops on numerous health topics including communicable diseases, injury prevention, nutrition, health education, dental health, and health screenings.

The collaborative model appeared to be the ideal method of enabling the Division to provide outreach to the community without a training budget of its own. A strong affiliation was formed with the Association for the Education of Young Children affiliates throughout Massachusetts by jointly developing a preschool transportation safety project. Once again, the Division provided its training expertise and coordination capacity to a group of AEYC members who were trained to become speakers on preschool passenger safety.

During 1984, the Division strengthened its ties to the day care community by co-sponsoring a full day AEYC conference. The keynote speaker on child sexual abuse and seven additional workshop trainers were provided by the Division.

The Preschool Enrichment Team is also a fine model of technical assistance activities for day care. This multidisciplinary preschool preventive health team works intensively with forty programs. Their productivity is apparent from the fact that during 1985 they completed 643 school visits, screened almost 1200 children for hearing loss, held 85 training and in-service programs serving 2108 attendees, in addition to providing many other services. They have become even further integrated into the day care community by receiving Office for Children funding to become a Child Care Resource and Referral Agency for Western Massachusetts.

The Health in Day Care guide is an illustration of written technical assistance materials developed specifically for day care. Specific guidelines are presented, as are clear procedural recommendations, sample letters for parents, posters on handwashing and diapering, checklists for center and playground safety, and an outline for comprehensive health policies. "Safe Day Care" is another example of technical assistance for this constituency. Developed by the Statewide Comprehensive Injury Prevention Program of the Division, this module (which includes both a training manual and curricular materials) specifically focuses on the needs of the classroom teacher.

Technical assistance, in collaboration with the Preschool Health Program, is provided by a variety of other Division programs. The Massachusetts Passenger Safety Program trains speakers for workshops in early childhood programs and disseminates training materials. The Office of Nutrition is providing workshops for day care and is beginning to plan for the potential of developing a health/nutrition newsletter with the Preschool Health Program. Staff members of early intervention programs often provide technical assistance to day care programs around children who attend both early intervention and day care programs,

or children being transitioned from one to the other. The Division vision and hearing program trains day care providers to do screening. Outreach and Training Teams work with both family care providers and day care center personnel to assist them in serving children with special needs.

Another tier of activity of the Preschool Health Program is networking and promoting the awareness of health in day care on the national level. Conference presentations have been made to the National Association for the Education of Young Children (NAEYC), the Association for the Care of Children's Health (ACCH) and a future presentation is being planned for the American Public Health Association (APHA). Through networking at the 1985 NAEYC conference, an informal national network of health in day care professionals has been formed with individuals throughout the country. As a result of this effort, the Preschool Health Program has established a new working relationship with the Georgetown University Child Development Center to develop a complementary teacher's guide and trainer's guide to accompany *Health in Day Care: A Guide for Day Care Providers* for national distribution.

4) Provision of services: To provide direct services to meet established needs.

In this case, the MCH/CC Agency does not provide direct day care slots for children; nor is it appropriate for this agency to do so. However, the Division does provide a variety of services, which amplify and support the capacity of the day care system, for the preschool population with special needs. Such services include early intervention services (currently serving 5,000 children), developmental day care, integrated preschools (serving disabled and able-bodied children together), and respite care services.

Benefits of Collaboration

Due to the lack of program staff and training funds, the Preschool Health Program has been forced to assume the role of coordinator and facilitator. The program functions as a catalyst to others to see that the task of improving health in day care is addressed. This has become a productive role to foster inter-agency investment in health promotion in day care.

The recent involvement of the Department of Public Health as an integral state agency in day care policy and services has been the result of establishing a presence of health as a prominent day care issue. This recognition has occurred as an outgrowth of activities such as affiliations with other agencies and professional associations, public notice at conferences and in local publications, participation on relevant task forces, and development of a federal family day care project in response to expressed needs.

The receptivity of the day care community and other state agencies is a primary reason for the Preschool Health Program's success. At this historical moment, when day care has become a growing necessity of this society and when day care staff have not previously been exposed to health education or training, the need and desire for health information is a powerful driving force. Since the Massachusetts Department of Public Health is not the licensing authority, the Preschool Health Program has been greeted with enthusiasm rather than fear or resistance. And since health expertise is not a strength of other state agencies or the day care community, MCH is regarded as expert in a field which desperately recognizes the need for assistance in health. Rather than battling over "turf issues" MCH is welcomed as a long-lost missing piece of the puzzle. When the *Health in Day Care: A Guide for Day Care Providers* in Massachusetts is disseminated in 1986, both interest and requests for service are anticipated to increase significantly.

PROBLEMS

The major problems of the Preschool Health Program have been due to fiscal constraints. The Preschool Health Program can operate successfully only with cooperation from other staff within the Department of Public Health and other agencies. Because expansion proposals for state funds have not yet been successful, the Preschool Health Program operates on a yearly budget of approximately $35,000, with only one state position assigned to the program.

Other problems relate to the day care community itself—issues of low wages, high staff turnover, the high cost and unavailability of insurance, charges of child abuse and neglect, etc. Day care providers tend to be overwhelmed by the burdens of being understaffed, underpaid, and undervalued. A great deal of energy has been siphoned off to address these continual crises. The Health in Day Care reference manual and staff training and support are attempts to decrease this crisis orientation and to make the day-to-day management of health services in day care more understandable and attainable. However, building a solid basis for health in day care can only proceed as rapidly as the underlying foundations for day care itself are strengthened and expanded.

RESULTS

The Preschool Health Program, within several years, and with only part-time staff, has been established as a viable MCH program. Although expansion is desperately needed on the regional level, the Preschool Health Program has been able to act as a catalyst for health in day care activities. Although no formal evaluation has occurred to date, evidence of success can be measured by many concrete events which illustrate the recognition of health as an issue and the success of a collaborative model. The following are but a few examples:

- The Preschool Health Program represents the Department of Public Health on five interagency working groups to develop day care policies.
- Boston AEYC, without co-sponsorship, will include at this year's full day conference six health workshops by MCH personnel, including injury

prevention, communicable diseases, lead poisoning prevention, sick child care, and child passenger safety.

- A new Request for Proposals for Outreach and Training Teams issued by the Division will mandate them to provide consultation to day care providers to assist in the integration of children with special needs into both center-based and family day care programs.
- A county extension program has asked the Preschool Health Program and the Divisions's Office of Nutrition to collaborate on a comprehensive nutrition in day care training program.
- The MCH/CC Agency received federal MCH funding to implement a model family day care project aimed at promoting health and reducing health risks in family day care settings.
- Participation on the Citizen Involvement in Day Care Quality Committee resulted in revised and new standards for day care services.
- A Request for Proposal, to be issued by the Office for Children to all state-funded child care resource and referral agencies for the development of model training programs, lists health as one of its top priorities.
- Funding for a preventive child abuse and neglect training program for day care personnel sponsored by the Department of Social Services was saved after communication by a Division child sexual abuse working group (of which the Preschool Health Program director is a member).
- The Preschool Health Program represents the Department of Public Health on a task force which will recommend to the Office for Children a comprehensive state approach to family day care, including regulations and policy changes.
- The Statewide Comprehensive Childhood Injury Prevention Program (SCIPP) will disseminate a training model, "Safe Day Care". SCIPP staff have written two chapters on safety for the Health in Day Care guide and, in turn, the Preschool Health Program director assisted in development of the SCIPP module.
- The Division pediatrician has provided forums on AIDS throughout the state specifically for day care, early intervention, and other preschool program staff. She has also been actively involved in presenting workshops on communicable disease control and has assisted in the writing and review of the Health in Day Care guide.

EVALUATION

No formal evaluation has been undertaken to date. The Division is in the process of developing data management procedures to document more systematically its consultation and technical assistance activities. The Family Day Care Health Project has a specific evaluation component and its findings will have a major impact on future directions for the Division. Funded project activities are also monitored both fiscally and programatically on a semi-annual basis.

RECOMMENDATIONS

Our major recommendation to other MCH agencies is that health in day care initiatives should be undertaken, even when funding is insufficient. It has been demonstrated that despite low staffing, a reasonable impact on day care services can be achieved. Consideration of the following recommendations based on experiences in Massachusetts may be helpful.

1. MCH agencies should take a leadership role to promote health issues for day care even in states where they do not have regulatory authority for day care. MCH can help regulatory agencies build a health component into day care.

2. Any preschool health initiative should include a needs assessment process to determine existing needs and resources and future directions of the project.

3. MCH agencies should do initial active outreach to other state agencies and the day care community. While MCH expertise was welcomed, it was not solicited at the beginning without encouragement. Outreach should include professional group affiliations, day care publications, and advocacy groups.

4. The director of a day care initiative should have training and direct experience in day care settings.

5. To maximize learning and sharing, training opportunities should be open to as many preschool groups as possible—Head Start, state-supported and private day care, nursery schools, family day care, etc.

6. Workshops and even full-day conferences have been most successful when health is the entire focus. Health workshops at a broad conference which compete with priority day care topics such as behavior management tend to be attended by fewer participants.

Developing and implementing licensing regulations

An example using nutritional standards

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ABSTRACT

Regulations and standards are necessary in an effective child care licensing program. Their development is usually intricate and time-consuming, but the process itself enhances implementation.

Mississippi's nutrition project involved both regulation development and implementation. The evaluation of nutrition practices in child care facilities included development of an evaluation form, guidelines and training. Major deficiencies, which ranged from inadequate meals to unposted menus, were identified in 72% of facilities surveyed.

Cooperation between staff of several divisions within the Department of Health accounted for the success of the project and its continuation as an ongoing program.

INTRODUCTION

"Mississippi to me is the beauty spot of creation—a dark, wide, spacious land that you can breathe in" is Tennessee Williams' description of Mississippi. The state has over 47,000 square miles and is located in the geographic center of the South Central United States. The population in 1980 was 2,520,638 or about 53 persons per square mile. It is a very rural state where only 10 counties out of 82 have a total population exceeding 50,000; only three of these exceed 100,000 and just one exceeds 200,000.

Mississippi is a "young" state. One out of every three persons is under 18 years of age. Of these children about 19 percent live with one parent. There are 210,155 women in the labor force who have young children; 92,586 have children under six years of age. Mississippi has the lowest per capita income in the United States and 77,110 or one-third of our children under six are living in poverty.

Currently there are about 1200 licensed child care facilities in Mississippi. Of these, about 25% are Head Start Centers, 65% are centers serving over 15 children and the remaining 10% are family homes serving between six and 15 children—all under the age of six years. Facilities serving less than 6 children or those classified as part of school systems are not regulated in Mississippi.

The Child Care and Special Licensure Division is part of the Bureau of Preventive Health within the Mississippi State Department of Health. It is specifically located in the Division of Disease Control. The Mississippi State Board of Health is the governing board of the Department of Health and has the regulatory authority for Child Care Licensure.

The Mississippi Child Care Licensing Law was enacted in 1972 "to promote the health and safety of the children of this state" and "to assure that certain minimum standards of cleanliness and safety are maintained in such facilities." The law also states "that inspections and approvals shall be based upon the standards prevailing in the political subdivision in-

volved, and upon regulations promulgated by the State Board of Health."

The development of regulations and standards, or revisions thereof, is a slow process. Even minimal standards require careful study and review so as not to conflict with or in any way attempt to circumvent the intent of the legislation. In Mississippi, this development and review process takes several steps. First, within the Department of Health those persons responsible for the specific aspect of the program draft proposed regulations and/or standards based on their own expertise and knowledge. The regulations are then reviewed by others within the department who may be responsible for some phase of their implementation. Thirdly, the draft regulations are submitted to the Child Care Advisory Board (as established by law) for the Board's review and comments. At each step of the review process, appropriate recommendations are incorporated into the draft and presented at the next level of review. A public meeting constitutes the fourth review level in the process and is certainly one of the most important because of the possible political impact. When these reviews have been conducted and necessary changes have been incorporated, the regulations are submitted to the State Board of Health for a fifth and basically final review. When approved by the Board, the regulations are submitted to the Secretary of State, where they must reside for thirty days prior to implementation.

Even though this is a lengthy process, it does assure public awareness and input. Since there has been overall concurrence prior to final approval, this process further enhances the regulations' implementation. The following description of a specific project demonstrates that implementation of regulations and standards is often as difficult and as slow a process as development and approval.

NUTRITION EVALUATION PROJECTS

Shortly after the Mississippi Child Care Licensing Law was enacted in 1972, regulations for minimum standards of health and safety were developed as prescribed by the law. However, it was not until 1976 that minimum standards for nutritional care were included in the child care regulations. Written by Vonda Webb, R.D., then State Nutrition Director, the minimum standards specified the minimum serving sizes required for meals and snacks to provide one-third to one-half the Recommended Dietary Allowance. The serving sizes were based on the meal pattern chart used by the School Food Service Program for Type A lunches.[1] Portion sizes were adjusted for preschoolers. The standards addressed proper infant feeding practices and food preparation, appropriate mealtime atmosphere, supervision and requirements for writing and posting of menus.

Even though nutrition standards were included in the child care regulations in 1976 and such information was distributed to day care providers, lack of nutrition staffing in the Division of Child Care Licensure restricted evaluation of the program. In 1985, a portion of a state-level nutritionist position was funded and an evaluation of the nutritional program in licensed day care facilities was initiated.

The first thrust of the evaluation focused on a review of the standards as originally developed in 1976. The process involving development of regulations and standards as described above was followed and minimum standards for nutrition were developed and then approved in January, 1986.

During this same time period, another major focus was on the evaluation of nutrition practices in the day care facilities themselves. Existing public health nutrition staff were used to conduct these evaluations. The purpose was to assess the meal served, menus, food service and the adherence to nutritional standards by the child care facility. Since there were 1,200 licensed child care facilities, it was not feasible to evaluate a large percentage—hence a goal of evaluating 10% of existing centers and 50% of provisionally licensed facilities was agreed upon.

The majority of nutrition staff were receptive to the project. Coupled with the support of the Directors of Nutrition, Child Care, and Sanitation was the willingness of most nutritionists to accept this non-clinic based role in nutrition intervention. Despite limited time to devote to child care evaluations and limited travel funds, nutritionists coordinated visits to facilities with the local sanitarians as they made their regular licensure inspections. Before evaluations could be done, however, development of evaluation forms and guidelines for conducting evaluations were needed. The guidelines as developed were based on the nutritional standards regulations and were divided into five main topic areas: nutrition, mealtime, menus, special dietary concerns and infant feeding. By interviewing and observation the nutritionist was to determine certain basic facts which included but were not limited to:

1. Is the number and spacing of meals and snacks consistent with the hours of operation?
2. Is the meal or snack nutritionally adequate as prescribed in the standards?
3. Are the meals and snacks prepared and served under sanitary conditions?
4. Is the food served in a form easy for children to handle and not highly seasoned?
5. Are the children served promptly?
6. Is an adult sitting with children during mealtime?
7. Are eating utensils and furniture age and size appropriate?
8. Is the atmosphere pleasant and without tension, threats, or punishment?
9. Is the menu accessible to parents and written at least one week in advance?

[1] *National School Lunch Act. Public Law 79-396, 79th Congress, June 4, 1946, 60 Stat. 231.*

10. Does the menu include a variety in type of food offered—color, flavor, shape and temperature?

11. If a special diet is necessary, are diet instructions provided by parents and posted in the food service area?

12. If special diet foods are furnished by the parent, are they stored and served properly?

After the standards and guidelines were developed, in-service training was provided to district and local nutritionists statewide through district staff meetings. The objectives of training were to review the nutrition standards and to assure uniform evaluations using a standardized evaluation form. Since uniformity is the key to appropriate and meaningful evaluation, and to indicate the need for further action, the following specific instructions were also included in the training material.

1. Assess nutritional adequacy, menus, mealtimes, special dietary considerations, and infant feeding practices using "Guidelines for Nutrition Evaluation Visits" during site visit.

2. Note deficiencies in any of these areas. If you need to list multiple deficiencies, do so in separate report. Send copy to the day care center director and a copy to Child Care.

3. Complete all items on "Nutritionist Evaluation Form for Child Care Facilities.

4. Discuss your evaluation, deficiencies noted, corrective action needed, and your follow-up plans with facility director or person in charge at the end of your visit.

5. Obtain director's (or person in charge that day) signature on form.

6. Leave pink copy of form with director of day care center; file original, and send yellow copy to Child Care.

7. Refer deficiencies noted in food service sanitation to your local sanitarian for follow-up.

8. Make at least one follow-up visit, then refer to Child Care if your schedule does not permit further follow-up visits.

In order to assess the deficiencies noted and to identify follow- up needs a monitoring procedure was established. Copies of evaluation forms were submitted to the nutritionist in Child Care Licensure where each form was logged and filed. Using that information, semi and annual reports of the nutritional evaluations were compiled.

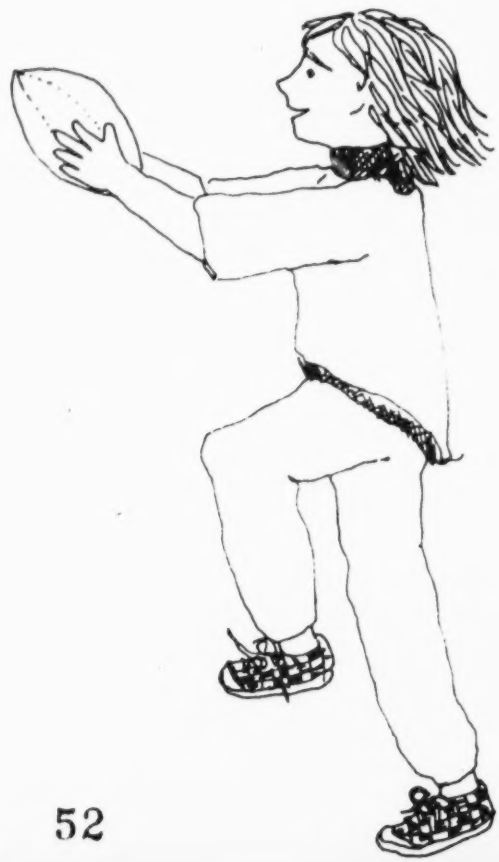
During the 1985 calendar year, nutritionists conducted 186 on-site evaluations at child care facilities statewide. Of these, 28% were new facilities and 72% were existing facilities. Additionally, 83 follow-up visits were made to those facilities where deficiencies were noted.

Major deficiencies identified were:

- Inadequate meal/snacks and menus
- Improper infant feeding practices (i.e., bottle propping, feeding from jar, using infant feeder, bottles and jars not individually labeled and lack of feeding schedules)
- Tea and Kool-Aid substituted for milk at lunch
- Menus not posted including posting of changes on menus Only 28% of the facilities evaluated showed no deficiencies. Where deficiencies were noted, problems were corrected on the second evaluation in 77% of the cases.

Goals of the project were met since that 134 existing and 52 newly licensed facilities were evaluated. The goal for existing facilities was exceeded by 10% but was under-achieved by 16% for the newly licensed facilities.

Major Deficiencies Noted	**Number of Specific Deficiencies Noted**
1. Inadequate meal, menus	72
2. Improper feeding practices	22
3. Tea, koolaid substituted for milk	22
4. Menus not posted (Substitutions not noted)	27
5. Thawing meats on counter	2



Nutritionist Evaluation Visits, Existing Centers
January 1, 1985 - December 30, 1985

District	No. of Centers to be Evaluated	No. of Centers Evaluated 1/85 - 6/85	No. of Centers Evaluated 7/85 - 12/85	% Goal	No. of Follow Up Visits 1/85 - 6/85	No. of Follow Up Visits 7/85 - 12/85	No. of Nutritionist Evaluating 1/85 - 6/85	No. of Nutritionist Evaluating 7/85 - 12/85
I	8	2	9	138%	-	1	2	5
II	15	6	7	87%	1	10	3	5
III	16	-	26	163%	-	2	-	5
IV	12	22	3	208%	6	3	7	5
V	29	15	2	59%	10	12	1	1
VI	9	1	1	22%	1	-	1	1
VII	8	2	0	25%	-	-	1	-
VIII	12	14	5	158%	5	6	11	7
IX	13	2	17	146%	-	7	2	6
Totals	122	64	70	110%	23	41	28	35
		134			64			

Goal - 122
Evaluated - 134
134÷122 = 110%

CONCLUSIONS

The project was successful in that deficiencies in nutritional quality of meals planned and served were identified. Also, awareness of and adherence to nutritional care standards were increased by both child care providers and department staff responsible for licensure of the facilities. Since the goal set for new centers was not met, future plans will focus on evaluating all newly licensed facilities. Other goals include provision of menu planning and food budgeting workshops and the training of department staff and child care providers on the revised nutritional care standards.

The project demonstrated that nutritionist evaluations and consultations are of tremendous need in the majority of our child care facilities in Mississippi. Further, it also demonstrated that through the cooperative effort of several existing divisions within the agency as well as the cooperative efforts at the district and local levels, the goal of providing better services to the citizens of the state can be achieved. As we strive to provide better services or to maintain existing services with ever decreasing resources, this type of cooperative team effort may be the key for which we have been searching.

Centralized licensing in public health services

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ABSTRACT

Approximately 2 years ago, the State of New Hampshire transferred child care licensing to the Division of Public Health Services at a time when there were conflicting opinions about how the child care licensing program should be administered, a serious shortage of day care, and a great deal of concern for the plight of children in licensed and unlicensed facilities.

The transfer and centralization of child care licensing was conceived by a legislative committee which was authorized by state law to conduct management reviews of state functions and make a report of findings and recommendations. Shortly following the publication of the committee's report, legislation was enacted authorizing the Commissioner of the Department of Health and Welfare to implement the transfer. An implementation plan was created by an interdepartmental committee and the child care licensing bureau was officially centralized in the Division of Public Health Services on October 1, 1983.

One of the immediate tasks facing the new bureau was revising public criticism and alleviating apprehensions as well as correcting a number of poor operational practices.

Placing child care licensing in the Division of Public Health Services proved to be a positive influence in gaining the trust and support of the child care facilities and public. Consolidating the child care licensing program in a central location was a critical factor in establishing and maintaining a successful program.

We believe New Hampshire's child care licensing program has been significantly improved primarily because of centralization in the Division of Public Health Services. It is hoped that the New Hampshire model will serve as a guide to those who are also encountering similar licensing problems.

INTRODUCTION

On October 1, 1983, the responsibility for licensing of child day care facilities and residential child care facilities in New Hampshire was transferred to the Division of Public Health Services. A new bureau was formed—the Bureau of Child Care Standards and Licensing. The responsibility of this bureau is to license approximately 540 family day care and family group day care homes; 500 group day care centers (including kindergartens, nursery schools, after-school care, and night-care facilities); and 25 residential facilities for children. These facilities provide child care services to a primarily rural population of 920,610 residents among which are 65,512 preschool children and 35,180 one-parent families.

This bureau is one of four bureaus within the Office of Health Protection. The others are Health Promotion, Health Facilities Administration and Emergency Medical Services.

The Bureau of Child Care Standards and Licensing is staffed with a bureau chief, licensing supervisor, eight licensing specialists, an administrative

secretary/supervisor and two secretary-typists. Licensing specialists are assigned to regional areas and are provided with an office central to their regional assignments. All licensing specialists report by phone to the state central office (the Bureau) daily for messages, investigation assignments, and to identify changes they wish to make to their work schedule. Licensing specialists are assigned to geographic work boundaries, however boundaries may be changed to equalize workload. Licensing specialists responsibility and assignments are limited to investigating licensing complaints, monitoring licensed child care facilities and licensing applications.

Office secretaries are responsible for all other administrative functions including data entries, responding to inquiries, intake of complaints and request for licensing applications, maintenance of the licensing records and production of management reports.

The average workload per licensing specialist is approximately 120 licensed facilities. In addition, licensing specialists average three to four investigations per month and monitor licensed facilities at least two times in a two year period, one of which must be unannounced.

Child facility licensing records are maintained in the state central office. Licensing specialists do not remove the licensing record from the office and are provided with a licensing working record and a number of computer-generated management reports to assist them in scheduling and controlling their workload.

Prior to the licensing responsibility transfer, child care licensing was organized according to county lines and administered in twelve offices by twelve Social Service Supervisors. The range of licensed facilities for which these supervisors were responsible fluctuated from a low of 22 to a high of 200.

Most of the licensing specialists were responsible for many of the administrative functions such as the control of documents required for licensure, licensing intakes and consultation functions, and day care service authorization. Many of the licensing specialists were required to carry out social work responsibilities in addition to the licensing duties. The licensing record was maintained in one of the twelve offices across the state and all licenses were issued from a state central office.

This organizational structure led to many problem situations which were prioritized and corrected by the new bureau. The following are two examples of such situations.

1. A day care center with 180 children had been licensed from January of 1974 through October of 1982. In 1982 several long-standing deficiencies were identified at this facility. Among them were: The local health officer's report identified that cleaning and maintenance was inadequate; no hot water, no soap, and no towels were available in the bathrooms; nutritional needs of the children were not being met; and there was poison ivy in the play area. The fire chief identified many deficiencies, such as: No fire extinguishers in the building, combustible materials stored under the stairs, the furnace room was not adequately protected from fire, and battery operated smoke detectors were being used. There was no fence around the outside play area as required. A site visit report had not addressed any of these issues; however a renewal of the license was never done. The facility continued to operate without making corrections to these dangerous conditions and without a license through October of 1983. By December of 1983, these conditions had been corrected.

2. A licensed family day care provider was identified as a perpetrator of child abuse in 1982. A child in this home had sustained bruises under her chin and very large bruises over her right buttock and lower back. The provider denied any knowledge of the bruises when questioned by the police, but later when the provider's husband turned over a statement to the police that he had "spanked" the child, the provider admitted to witnessing the whole thing.

STEPS OF IMPLEMENTATION/PROBLEM IDENTIFICATION

A Sunset Committee was established by the legislature to review the function of state agencies in New Hampshire. A report, which identified several areas for change to be of benefit to the citizens of the State of New Hampshire, was developed by the Sunset Committee in April of 1983 and transmitted to the Commissioner of the Department of Health and Welfare. The report recognized the lack of procedures for checking the police and child abuse records and character of people who applied for a child care facility license. Checking of applicants was limited to sending a form letter to three references provided by the applicants themselves.

The report included many other recommendations. One of these was the transfer of the child care licensing function including personnel, records, and funding to the Division of Public Health Services. It was also suggested that a new central office be set up and headed by a bureau chief with expertise in child development and rule writing procedures. In response to these recommendations, the legislature passed a bill, which included the provision that the rules and regulations for child care licensing be revised by April 1, 1984, transferring the licensing of child care to the Division of Public Health Services.

A committee made up of staff from the Department of Health and Welfare and the Division of Public Health Services began by reviewing workload standards, the number of licensed facilities, and number of staff involved in licensing activities. They also evaluated possible structures to deal with the specific categories of care to be transferred. By combining this information, they agreed to an organizational structure which would include a bureau chief, a temporary consultant, an administrative assistant, two supervisors, seven licensing specialists and two secretaries. They further negotiated a memorandum of agreement that

led to the transfer of nine experienced licensing specialists and funding for supportive and administrative positions to the new organization. This transfer officially took effect on October 1, 1983.

In September, 1983, a bureau chief was hired to coordinate the transfer and manage the Bureau. Initially this task included:

1. Arranging for office locations for the nine personnel who would be transferred.
2. Hiring of additional administrative personnel.
3. Arranging for the transfer of forms and equipment.
4. Hiring of a consultant to coordinate the revision of the rules and regulations.
5. Beginning implementation of a computer system for child care licensing.
6. Setting up a system for the review of transferred records.
7. Setting up an orientation program for the transferred staff.

Approximately 1500 records were transferred from 12 district offices to the Bureau's central office in Concord. These records were individually reviewed by the licensing specialists who were provided with a review checklist. This review process took approximately two weeks and included caseload debriefing by staff of the 12 districts.

A consultant was hired who was charged with setting up committees comprised of representatives of Family Day Care, Group Day Care, Day Care Nursery, and Group Home and Institution providers, legislators, and policy development experts to draft proposed revisions to the existing child care regulations. The consultant was the coordinator between the Bureau and the Day Care Advisory Committee and served as the chairperson of each sub-committee that was formed. The sub-committees met over a period of three months developing the proposed revisions of their assigned sections of the rules and regulations. The revised rules were adopted in April of 1984.

A management control system was started by compiling a master list of all licensed child care facilities with their license expiration dates, and a plan was developed to work on problems such as correcting incomplete records, license errors, and inconsistencies, and eliminating the backlog of expired licenses.

More than 50 percent of the child care licensing records were incomplete. Missing information included fire and health approvals, physicals, references, applications, etc. In many instances facilities were told by the licensing specialist to submit the forms, but in the interim, licenses or permits were issued. Approximately 150 records were missing altogether. Much of the information that was in the records was out of date, up to ten or more years old and irrelevant. Facilities which had been operating for many years sometimes had several folders of outdated or irrelevant information which needed to be discarded or sent to archives.

A review of the licenses issued revealed many errors and inconsistencies. This was due to the decentralized system of the previous agency which allowed the 12 different supervisory situations to interpret the licensing law, regulations, and policies independently. Therefore, there was little equity and consistency. In many cases, licensing or monitoring visits were never conducted before a license was issued. Facilities were seldom notified of results of monitoring visits and there was no evidence in the records of a request for a plan by the facilities for correcting problems.

Over 200 licenses had expired and had never been renewed.

There were often long delays in processing applications due to a previsit licensing system for responding to inquiries. Persons making inquiries were visited by the licensing specialist who provided forms and explanations of the licensing procedures. When the person submitted an application, a return visit was necessary to inspect the facility. If the person never submitted an application, or did not complete the application process, unnecessary visits had been conducted.

Variances granted or denied were difficult to identify because there was no uniform system for granting and recording. Some variances were authorized verbally by licensing specialists, and others were approved by the state office. This allowed inconsistencies in the variances which were granted and denied. The fact that too many variances were being granted was circumventing minimum standards and jeopardizing the health and safety of children in licensed facilities.

Complaints were often not well-documented in the licensing files. Often the investigation report was placed into the protective service record or a client record which was separate from the licensing record. There was no policy regarding notification to the complainant informing them of the results of an investigation. According to one of the transferred licensing specialists, in her six years of licensing experience, she had only received three licensing related complaints. This was inconsistent with the number of complaints received following the transfer of the licensing function to the Division of Public Health Services where an average of 30 complaints statewide are received per month.

There also were no enforcement provisions in regard to unlicensed facilities. The process for enforcement of the licensing law regarding unlicensed facilities was to provide an application package and request that they become licensed. In many instances, these facilities did not obtain a license and were permitted to continue to operate. An example of this problem concerns a complaint that had been received and investigated in 1982 of a facility providing care to 12 children. This facility was given an application form, and requested to become licensed. In October of 1983, the Division of Public Health Services also received a complaint that this facility was operating as an unlicensed facility. Upon investigation it was discovered that the facility had not applied the previous year because of problems obtaining zoning, health, and fire approval; however, the facility had continued to provide care to 12 children. This facility was prohibited from operating until it eventually

became licensed.

Because of the delay in establishing the central registry file on perpetrators, the Bureau was unable to issue a license during its first four months of operation. Once the registry was up and running it was found that many of the names in the file should never have been there. One such example concerns a male who held a job at a residential facility. When a central registry check was made, his name came up as a confirmed match for child neglect. Based on this information, the Division of Public Health Services informed the residential facility of his record and, under threat of revocation of their license, requested that the facility provide a plan for correction within 24 hours. The plan of correction provided by the residential facility was to dismiss this male from their employ. The employee appealed the case. During the appeal process, the facts of record were revealed. The employee's house had burned, all of his possessions had been lost, and his child had been sent to school in second-hand clothes. This resulted in the employee being reported for child neglect. The social worker who investigated the report entered a founded determination on the record. The employee won the appeal, and his job was reinstated.

PROBLEMS OF IMPLEMENTATION AND HOW THEY WERE ADDRESSED

The major implementation problem facing the new bureau was the large number of corrective measures needed and the massive volume of work required from a small number of staff. A little over two years have elapsed since the Bureau's inception and corrective efforts are continuing. During these first two years, the Bureau has made operational changes which address the problems, including the following:

1. A uniform filing system for all of the records has been established and implemented.

2. All facilities with expired licenses have been inspected and relicensed or closed.

3. A centralized system for new applicants has been set up. This administrative function, which was previously done by licensing specialists individually, is now done in the Bureau by secretarial staff. It includes processing an intake form with key questions for potential applicants, as well as training the secretarial staff to respond to questions regarding the licensing requirements and application process.

4. A consolidated licensing process has been developed for applicants. The process includes: (a) giving the applicant responsibility for arranging for health and fire safety approvals; (b) a form for all facility types which consolidates four different applications; (c) a current copy of the applicable rules and regulations for new applicants; (d) a form on which the applicant records the required information on all persons who would have contact with the children; (e) a cover letter explaining the licensing process and forms; (f) a supply of forms for personal physicals, child physicals; and (g) registration and emergency information forms for children.

5. Following the application process and a site visit by the licensing specialist, the applicant is issued a 6 month permit to begin operation. Prior to the end of the six month period, the licensing specialist conducts another site visit to determine compliance with programmatic requirements. Included with the permit are suggested sample forms and informational documents to assist the facility in its day to day operation.

6. A system has been established that requires documentation of results of licensing visits and a response or plan of correction from the facilities for licensing deficiencies identified during the licensing and monitoring visits.

7. A goal has been set to conduct a minimum of one licensing visit, and one announced and one unannounced monitoring visit for each facility during the two year licensing period. Controls have been instituted to assist licensing specialists in scheduling visits and to monitor progress in meeting the goal.

8. A computerized control system has been established. This includes scheduling of licensing and monitoring visits; control of overdue licenses, variances, and complaints; as well as results of licensing and monitoring visits.

9. Forms have been updated, consolidated, and revised to assure consistency of information in the records; to make them easier to complete and review; and to reduce the paperwork required for an application.

10. A system has been established for checking the criminal and child abuse/neglect records of all persons who have contact with children in licensed facilities. The Bureau has an agreement with the state police and the Division of Welfare to check for these records. A procedure has been implemented for the facilities, as part of the licensing and relicensing process, to submit the names and date of birth for each person who would have contact with the day care children. This information is then copied and sent to the state police for a criminal records check and to the Division of Welfare for a child abuse/neglect check.

11. A requirement has been established stating that no facility shall be issued a license until criminal and child abuse records have been checked and all people who will have contact with the children are cleared. Those individuals who are matched in either the police or abuse checks are investigated. A procedure has been established for investigating and documenting these cases. Facilities are required to call in the names and dates of birth of any new staff hired during the licensing period.

12. A system has been established to review the work of the licensing specialists to assure consistency in the application of the regulations and the licensing process. A checklist has been developed for conducting monitoring and licensing visits. Training has been provided on how to write deficiencies, and the licensing supervisor and administrative assistant review each

deficiency report. Inconsistencies and/or inaccuracies are brought to the attention of the licensing specialist for correction.

13. A system has been established to review variances. This places more responsibility on the facilities to justify the need for variances, and to allow for parents of children who are effected by the variance to be informed of the request. The variance review system has been designed to reduce risks to children in day care.

14. Criteria has been developed to assist the Bureau in the determination of denial or approval of variances. The internal variance review process consists of a review of and recommendation for the variance request by the licensing specialist and the licensing supervisor, and a review and decision by the bureau chief. Following a decision by the bureau chief, the administrative assistant checks for consistency in language and reasons for approval or denial with prior variances issued or denied.

15. An intake form has been developed to receive complaints and a manual complaint log has been established. A policy has been developed setting time limits for investigation of complaints. A control system to monitor this policy has been established.

16. The Bureau has developed a complaint investigation handbook which includes detailed procedures and guidelines for receiving, planning, investigating, evaluating, and documenting a complaint.

17. To assure that complete and timely investigations are conducted and appropriate determinations are made, investigation reports and determinations are reviewed by the licensing supervisor and the administrative assistant.

18. A procedure for investigating and dealing with unlicensed child care facilities has been established. A certified letter is sent to the unlicensed facility ordering them to stop operating within 24 hours of receipt. Followup visits are conducted to assure compliance with the order within a week of the date that the facility receives the letter. In instances where the facility does not abide by the order of closure, the matter is referred to the Attorney General's office for action. When the 24 hours' notice to cease operating was first instituted, many people felt it was excessive; however, in some instances the health and safety of children are in jeopardy. As an example, an elderly woman whose small home appeared to be packed with children was asked how many youngsters there were. She told the licensing specialist, "I don't rightly know, let's set everyone down and count them." There were 22 children present with only one provider. This was a very serious violation of the licensing law and was explained to the woman. She was sent the certified letter ordering her to close within 24 hours of receipt. At the followup visit it was determined that she had ceased caring for children in her home.

19. A checklist has been developed for the local health officers to use to make their inspection. This checklist assists the individual town and city health officers in uniformly applying the health codes. A supply of forms for making their inspections has been sent to each health officer.

20. In cooperation with the state fire marshal's office, a consolidated list of fire requirements has been developed for new applicants for a child care license. In addition, a new fire approval form for local fire chiefs has been developed and a supply is provided.

21. A regional training program has been implemented to provide free training opportunities for facilities throughout the state. This program has included training in discipline, safety, and recognizing special needs children in day care. Also, the Bureau has assisted in offering a statewide conference on health in the day care setting, which is now to be an annual event.

22. A working file separate from the facility record has been created and a checklist attached to it to make sure that required documentation is in the Bureau prior to conducting a licensing visit.

23. A procedure has been established for license visits to facilities with 50 or more children requiring that two licensing specialists conduct the visit together. This is done because in the larger facilities there is more paperwork to review and more children to observe. It also provides an opportunity for licensing staff to learn from each other and helps assure consistency in the reviews.

24. A peer review process has been established to monitor consistency in interpretation and application of the standards, and to assure quality reviews are being conducted by the licensing specialists.

25. With the cooperation of the New Hampshire Day Care Advisory Committee, subcommittees have been established to advise and assist the Bureau in developing standards and policy regarding health and injury prevention, survey procedures, and a Family Day Care Handbook.

26. The Bureau has developed a comprehensive employer supported day care informational packet which is available upon request.

STRENGTHS OF PROGRAM

Highly regarded among the major program strengths is the Management Information System. The computer reports allow us to generate management tools such as: a list of monitoring visits due each month; progress reports of the productivity of licensing specialists; work plan reports that allow us to project the workload for a yearly period; an updated master list of all facilities which is sent to the public upon request; a report of violations cited at each licensing or monitoring visit which is then used to compile compliance history on each facility and assist the Bureau in developing future educational programs; a report of all complaints received; the results of complaint investigations, and a report of variances issued or denied. This has greatly increased the ability of the Bureau to manage workloads, achieve consistency in

its methods and to operate more efficiently.

By eliminating forms, streamlining the licensing process, and the consolidating the licensing and operating requirements, the time necessary to obtain a license has been reduced. The facility's ability to understand the licensing and monitoring process has also been improved. In fact the Bureau has streamlined the licensing administrative process so much that an applicant may receive a license within one week after the completed application package is submitted. The process includes performing a police and abuse check, a site visit by a licensing specialist, providing a Statement of Findings of the site visit to the applicant, and the issuance of a license.

Since the program has become a part of the Division of Public Health Services, child care facilities have been viewed more favorably by the public, thus increasing public support of the licensing program.

Since the facilities now have input, they have become involved in the licensing process and the development of standards.

A policy of not compromising the child care facility licensing standards has led to a respect of the program by parents, facilities, volunteer and professional organizations, and federal, state, and local agencies.

Administrative functions such as intake (both for licensing information and complaints), requests for forms and general questions regarding the licensing standards are handled by the secretarial staff in the central office and are no longer the responsibility of the licensing specialists. This allows the licensing specialists to devote maximum time to conducting complaint investigations and licensing and monitoring visits.

The New Hampshire child care facility licensing program operates independently from any child placing agency. This is a strength because the focus is on assuring safe and quality facilities for children and parents, not operating as a crisis management system having to locate and license facilities in which to immediately place children.

RESULTS

The transfer of the licensing function has resulted in many positive changes which are of benefit to parents and children, as well as child care facilities. Many situations which were harmful or damaging to children have been identified and corrected. Some of the many situations that have been encountered and corrected are:

- Unlicensed facilities caring for large numbers of children were stopped from operating. Many of these facilities were assisted in complying with the licensing law and becoming licensed for a safe number of children.
- Persons with previous records of sexually or physically abusing or neglecting children have been prevented from being employed in or operating a child care facility.
- Outside play areas which previously had access to dangers such as heavily travelled roads, have been required to be fenced.
- Guards around wood stoves and radiators in child play areas have been required.

STATISTICS

These statistics reflect the period October 1, 1983 December 31, 1985:

Number of licensed child care facilities in NH	999
Number of licensed day care slots	22,396
Number of complaint investigations	536
Child care staff removed from employment due to child abuse records	6
Facility licenses revoked/denied due to sexual abuse of children	8
Incidences of closure of unlicensed child care facilities (80% of those went on to become licensed)	167
Number of overdue licenses	0
Number of Licensing/Monitoring visits conducted	2,355
Number of corrected licensing violations	8,200

Since October 1, 1983, the Bureau has achieved the following:

- Consolidated and clarified the standards
- Conducted police and abuse/neglect records checks on all persons having contact with children in day care facilities
- Improved the number of monitoring visits in each two year licensing period from 12% of all facilities receiving 2 monitoring visits in 1983/1984 to 58% receiving 2 monitoring visits in 1984/1985. In 1984/1985 only 5% of the facilities lacked monitoring visits as compared to 48% during the 1983/1984 period.
- Provided for consistent application of the licensing regulations
- Investigated child care facilities which were operating in violation of the licensing law
- Established a peer review process for licensing specialists
- Computerized the licensing records
- Developed a guideline to investigate and document complaints against licensed and unlicensed child care facilities
- Developed a variance review process and criteria for approval or denial
- Established an employer supported day care packet to assist employers in understanding the pros and cons of the various ways to assist employees with day care
- Developed facility training on health, safety, nutrition, and discipline

- Provided up-dated lists of child care facilities to the public and Information and Referral offices
- Developed positive public relations for the child care facility licensing program

We conclude that child care facility licensing is a program which should be separate from a user program in order to eliminate conflict created by one single program which licenses facilities and recruits placement facilities. Regulatory requirements are less likely to be overlooked when licensing is separate from the user agency. Most public health agencies have regulatory and programmatic experience in the licensing of adult facilities, and much of this experience can be applied to child care facilities.

EVALUATION

The Bureau of Child Care Standards & Licensing has taken many positive steps to increase the efficiency and effectiveness of the child care facility licensing program and has used many tools to evaluate this progress.

One of these tools is the use of pie charts to measure progress in achieving the goal of two monitoring visits per facility per licensing period (see appendix). This chart helps to evaluate the efficiency of each licensing specialist within the Bureau and the Bureau as a whole. Progress has been a gradual, developmental process. A comparison of monitoring visits for licenses which expired in the first six months of calendar year 1985 with the first six months of calendar year 1986 showed improvement in the licensing specialists' use of time to manage workloads according to established priority.

Another tool used to manage workloads is a monthly productivity report combined with a yearly report of anticipated monthly workload. This tool allows licensing specialists to plan work time so that they may shift visits to balance their workload. Management can also assign special duties in accordance with projected workload.

A facility evaluation was conducted aimed at reviewing the day care regulations for appropriateness and effect (see appendix). This will aid in further revisions of the standards.

A facility survey of the licensing process was conducted to evaluate how licensing visits were being perceived. The results were tallied (see appendix), giving valuable feedback on ways to improve the licensing visits, and confirming that the licensing specialists are regarded positively by the facilities.

By use of a computer system, a listing of all the violations cited as a result of licensing and monitoring visits has been developed. This listing shows risks to children that have been identified and corrected over the past two years (see appendix). This listing has assisted the Bureau in determining inconsistencies in interpretations of licensing standards by licensing specialists and has helped identify areas of need for training of facilities.

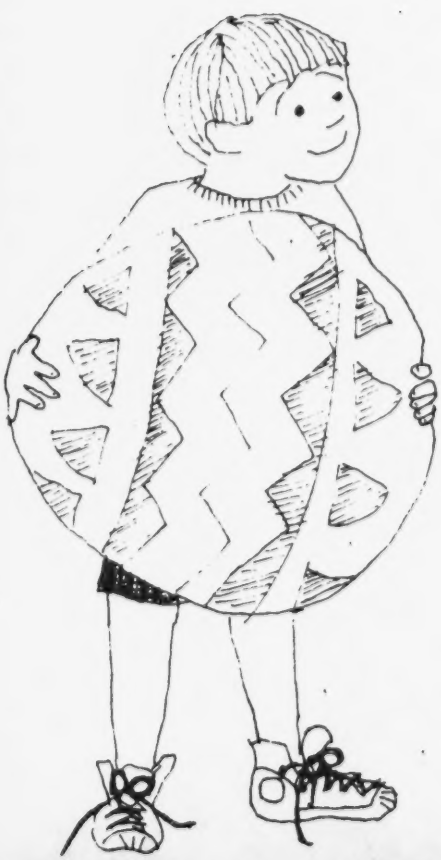
In conclusion, we hope to continue to improve the licensing program and the process of evaluating its effectiveness.

RECOMMENDATION

From the Bureau's experience of the past two years, the following are recommended for consideration by Public Health Agencies who are licensing child care facilities or who will be assuming this responsibility:

- Consolidate the administrative responsibility for licensing within one unit.
- Develop a system of checks and balances for review of the process to insure consistency, timeliness, accuracy, and quality.
- Seek facility feedback.
- Establish a computer system for licensing records.
- Train staff in new procedures.
- Remove licensing specialists from application activities.
- Share productivity reports with licensing specialists on a monthly basis.
- When receiving large numbers of transferred records, develop a retention and organizational policy for the records, review the transferred records, remove any material which is irrelevant or inappropriate, organize materials in the record according to the retention and organizational policy, identify missing information, and check for current and accurate licenses. Send a notice to facilities identifying missing information and ask for a response by a certain time in order to reconstruct records.
- Evaluate the program often.
- Review the number and type of forms required including the forms to obtain a license. Try to consolidate forms as much as possible to simplify the licensing process and therefore make it easier and quicker to obtain a license.
- Require the facilities to keep documentation such as children's and staff physicals, children's registration forms and transcripts of educational requirements of staff at the facility for review by the licensing specialists at licensing and monitoring visits.
- To avoid unnecessary work by licensing specialists, do not conduct licensing visits until all paperwork is in the office.
- To avoid missing records, allow only working files to leave the office.

Training of day care center personnel to perform health screenings



Submitted by: Brenda B. Coakley, M.Ed., Chief
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ABSTRACT

The Baltimore City Health Department Division of Child Day Care is the unit responsible for the licensing, overall regulatory supervision and the provision of technical assistance and consultation to licensees and prospective operators of all day care centers and day nurseries in the City of Baltimore. The Division is a part of the Maternal and Child Health Services Section. As such, the provision of auxillary health services to the day care centers is of primary concern.

When funding cuts eliminated the vision-hearing screening services performed by Health Department personnel, day care center staff were trained to use the audiometer and titmus machine and loaned this equipment in order to continue the screening component of the preventive health program for preschool age children.

INTRODUCTION

Baltimore, affectionately known as "Charm City", is one of the principal port cities in the United States and the largest metropolitan area in Maryland. Approximately one half of the state's population resides in the Baltimore City area constituting a population of 786,775 ranking the city 10th in population among United States cities according to the 1980 census.

Located on the Patapsco River which connects it with the Chesapeake Bay, an inlet of the Atlantic, Baltimore has one of the world's largest natural harbors, which facilitates the City's major economic resources: shipping, manufacturing industries and tourism.

Radar and electrical equipment, steel, fabricated metal products, chemicals, machinery and food products comprise the more than 2,000 industries in the metropolitan area, placing Baltimore as one of the largest industrial employers on the East Coast.

Extensive, innovative urban renewal projects sponsored by both the public and private sectors have resulted in the city's increasing popularity. As a result, habitation within the City boundaries has increased, necessitating the expansion of existing urban services programs and/or creation of service oriented facilities.

Accordingly, census tract data compiled by various State agencies definitely establishes the existence of a correlation between Baltimore's urban and economic development, which ehcompasses industrial growth, and the demand for increased out-of-home care facilitators to accommodate the rapid growth of the workforce.

In 1979 the median Maryland income for families with children under the age of eighteen was:

$26,841	White, husband-wife
$24,937	Black, husband-wife
$11,099	White, female-headed household
$ 8,717	Black, female-headed household

Maryland statistics for 1984, which are consistent with national data, show that 52 percent of women with children under 6 years and almost 50 percent with children under 3 years were working. During

1985 approximately 64,603 children were in regulated child care settings.

Single-parent (female headed) families represent 18.7 percent of 559,011 Maryland families with children under the age of eighteen.

A variety of regulated out-of-home day care services are available in Baltimore City. The largest group of child care providers is comprised of 1,000 registered family day care homes. Each provider may care for up to six children in his/her home. The second largest regulated form of child care is the group day care center where seven or more children may be cared for during a fourteen hour period. There are approximately 8,000 children attending the 184 licensed group day care centers and nursery schools in Baltimore.

However, it is overwhelmingly evident that the demand for child care far outstrips the current supply and availability of services. It is projected that by 1990 at least half of all preschool children in Maryland will have parents in the labor force.

The need for a range of child care services will not diminish, neither will the needs of those children in care. Both the public and private sectors have a responsibility to promote policies enabling parents to balance family and work responsibilities in ways that enhance the best interest of children.

IMPLEMENTATION

The Mayor and City Council of Baltimore (the City of Baltimore) is a political subdivision and body corporate and politic created and existing under the Constitution and Laws of the State of Maryland, and is authorized to perform certain functions pursuant to the Charter of Baltimore City. Specifically Article II, Section 11 authorizes the City to:

> "Provide for the preservation of the health of all persons within the City;..."

The Department of Health is an agency of the City of Baltimore established by city charter for the purpose of preserving the health of city inhabitants. The Baltimore City Health Department was established in 1797 and is the oldest institution in the county that has provided continuous health services to its community. The governance of the Department is set forth in Article VII, Section 47 of the Charter of Baltimore City as amended through June 30, 1973 and in Article 11 of the Baltimore City Code of 1983 Replacement Volume. The governing officer is the Commissioner of Health who is appointed by the Mayor, subject to the approval of the City Council. Within the Commissioner's office are included the Health Policy Analysis and Public Information functions and the liaison with the Department's various advisory boards.

The remainder of the Department is composed of an administrative section and operating sections. Five of the operation sections are under the supervision of the Deputy Commissioner for Medical Services. These include: Environmental Section, Aging and Community Health Services, Children and Youth Services, Clinical Services, and Maternal and Infant Services. Mental Health, Mental Retardation and Addiction Services, as well as Administrative Services are under the supervision of the Deputy Commissioner for Administration. School Health and Preschool Health programs are divisions/units within the Maternal and Child Health Section.

The School Health program brings together all Department of Health activities which provide health care to students in the Baltimore City Public School System. School health services for students are aimed at detecting health problems which may affect learning. With early intervention, the impact of health problems on the learning process may be prevented or diminished. Activities of the program include health services, health education and the maintenance of a healthy school environment. More specifically, vision and hearing screenings, immunizations, social and school services and services to handicapped children, and EPSDT comprehensive health clinics in seven secondary schools. School health services provide the opportunity for many children who do not have primary care providers to receive health assessment and health care. The program avoids duplication and fragmentation of health care to the school-aged child by acting as coordinating unit for the child's total health program.

Funds for this program are obtained from general revenue of the City and from the State Department of Health and Mental Hygiene.

Preschool Health Services are funded from general revenue of the City and by various State grants and include comprehensive health services (preventive health care, immunizations, treatment of illnesses, dental care and referral as necessary), U.S.D.A. Child Care Food Program administration for family day care providers, W.I.C. supplemental food program, Childhood Lead Poisoning Prevention, Child Day Care Center Licensing and High Risk Infant Follow-up Program.

In Maryland the statutory authority for licensing of group child day care centers has been delegated to the Department of Health. The first rules and regulations governing the operation and conduct of day nurseries in the State were adopted by the Baltimore City Commissioner of Health on October 25, 1934, in accordance with the provisions of Ordinance 270, approved July 25, 1932.

ARTICLE 12

Section 1. A Day Nursery is defined to be any institution, establishment, or place in which are received at one time two (2) or more children not of common parentage, for temporary guardianship and nursery care, apart from their parents or guardians, whether for compensation, reward or otherwise, during that portion of the day or night in which their parents or guardians are engaged in other pursuits and occupations than attending to and caring for such children.

Section 2. No person or persons or corporation shall conduct, maintain or operate, in Baltimore City, either as owner lessee or agent, any day nursery without having first obtained a license therefore from the Commissioner of Health, authorizing him, them

or it to do so. All such licenses shall be for the period of one year, and the charge of such license issued to any such institution shall be One Dollar ($1.00) and for the renewal of said license from time to time the charge shall be One Dollar($1.00) per annum.

Section 3. The Commissioner of Health is hereby authorized and empowered to make, adopt and enforce rules and regulations for the operation and conduct of said Day Nurseries and said Commissioner of Health shall, from time to time, inspect said Day Nurseries and require them to be kept in a proper sanitary condition.[1]

Because of health hazards resulting from communicable diseases prevalent in children under six years of age, the rules and regulations governing day nurseries were also held to apply to any nursery school, kindergarten day care center or similar institution serving children under six years of age.

Maryland State later adopted Article 43A01 REGULATIONS GOVERNING GROUP DAY CARE FOR CHILDREN on August 24, 1956, which became effective October 1, 1956. Baltimore City regulations have been amended six times since their initial adoption and Maryland State regulations amended five times.

Additionally, the Baltimore City Health Department has also been responsible for the licensing of the Family Day Care Homes, i.e. where care is provided to not more than four children in lieu of parental care.

With the establishment of the Family Day Care Licensing Act in 1966, licensing administration of family day care homes was transferred from the Commission of Health to the Director of the Baltimore City Department of Public Welfare, now the Baltimore City Department of Social Services. Before the issuance of an initial family day care license and annually thereafter, written approval of health and sanitary prerequisites based upon on-site inspections is furnished to the Department of Social Services by the Health Department.

The Division of Child Day Care is comprised of eight full time staff including four child development specialists: Division Chief, Division Assistant Chief, and two Child Day Care Center Inspectors. The remaining positions are a Senior Community Health Nurse, Day Care Nurse Coordinator, a Health Aide and a support staff person. Three Sanitarians from the Division of Institutional Facilities of the Environmental Health Section perform the environmental inspections. A registered nutritionist within the Maternal and Child Health Services provides pre-licensing consultation to prospective operators, consultation to licensees, workshops to day care center personnel and/or parents, and investigates complaints specific to the nutrition regulations.

An effective licensing program not only enforces regulations by supervising the facilities and determining conformance with standards, but it also provides consultation and technical assistance to prospective operators and licensees. This may be accomplished through a variety of methods:

Individual (one-on-one) consultation

On-site evaluations and prescriptive remediation

Group workshops and presentations

Newsletters and topical bulletins

Audio-visual presentations

With this in mind, in-service workshops on various health related topics have been sponsored and instructed by staff of the Division of Child Day Care. The subject area is determined by needs expressed by the licensee and/or operators, by the volume of documented non-conformity areas contained in the licensing inspection reports, and as mandated by regulation. These workshops have included some of the following topics:

- Basic Red Cross First Aid
- Nutrition—Food Planning and Buying for the Preschool Day Care Program
  —Snack Ideas
  —Basic Principles of Nutrition
- The Child Care Center's Role in Prevention and Detection of Child Abuse
- New Director's Workshop
- Money Saving Ideas—Fuel, Nutrition, Equipment/Donations
- Vision—Hearing Screen Training

As a part of the Maternal and Child Health Services, the Division of Child Day Care is the unit of the Health Department responsible for licensing and overall regulatory supervision of all day care centers in the City of Baltimore. As such, it is concerned with and has responsibility for providing auxillary health services to the day care center population. We support Dorothy Boguslawski's statement:

> The well-being of the child can be assured only if his total state of health is known, evaluated and improved. Parents are, of course, the ones who have the long range, continuing responsibility of their child's medical care. However when the day care center enters into partnership with a parent for care of the child, the center shares responsibility not only for maintaining the child's health but also promoting it.[2]

The Division of Child Day Care, as the licensing agent, provides the day care centers with resources and training to accomplish this. Vision and hearing screenings are now performed by day care center staff using Health Department equipment as a result of an on-going training program instituted by the Division. Prior to 1981, day care and day nursery children received vision and hearing screenings through the

[1] *Baltimore City, Ordinance 270 (1932), Art. 12, Sec. 1-2.*

[2] *Dorothy beers Boguslawski, Guide for Establishing and Operating Day Care Centers for Young Children (New York: Child Welfare League of America, Inc., 1966), p. 65.*

School Health-Hearing and Vision Services Program or the Maryland Society for the Prevention of Blindness. Due to reduced funding levels, Health Department screening personnel were exclusively limited in provision of service to the mandated school age population. The Division received numerous inquiries about continuing the screenings citing the value of early detection in preventing problems and identifying perhaps heretofore undiagnosed impairments. The delivery of those needed health services to all children in the City of Baltimore remains our primary goal. This goal was accomplished and continues to be realized by innovative and energetic management and administrative support.

The regulatory responsibilities in licensing of child day care centers has always been a team effort. Encouraged by the Assistant Commissioner for Maternal and Child Health Services, the Audiologist of the Vision and Hearing Screening Program and the Chief of the Division collaborated to determine how best to utilize our limited resources and manpower. The 165 licensed day care centers and day nurseries (full day and part-day programs respectively enrolling 6,500 children) were initially polled by questionnaire to determine their interest in continuing this service and their willingness to have staff released to be trained to provide the service. We hypothesized that testing by center staff with whom the children were familiar would possibly result in increased accuracy of results and numbers of children tested. The response was overwhelmingly supportive. An example follows.

ATTACHMENT I

Dear Director:

I am sure you are aware of the limitations placed on funds and personnel which had served as resources to your day care center/nursery in the past.

As a result of these shortages, we are initiating a self-help screening effort. Instruction in vision and hearing screening techniques is being planned by the Division of Child Day Care's Day Care Nurse coordinator and the Hearing and Vision Services Program.

All interested personnel are asked to please contact the Child Day Care Division office at 396-4465 by _____ in order that we may make definite arrangements.

We look forward to your participation.

Sincerely,

Brenda B. Coakley, Chief
Division of Child Day Care

A training site easily accessible by public transportation, within the child care community with adequate space for lecture and demonstration was selected from the licensed child care centers. Due to the number of respondents, it was necessary to limit workshop enrollment and schedule several other workshops to insure a positive learning experience and opportunity for individual practicum. Following our team approach, the Day Care Nurse Coordinator and Audiologist co-instructed the course. The Day Care Nurse Coordinator, a senior community health nurse, had performed this service and follow-up to children visiting the well-baby clinics and public school children. She is also the primary Baltimore City Health Department resource to the Maryland School for the Blind and Gateway Preschool (hearing and speech agency) early childhood programs; and she teaches the basic first aid course(s) to day care center personnel. The Audiologist had maintained an ongoing professional interest in the day nursery/preschool population and possessed the knowledge, skills and technical expertise to perform the screenings.

In the first year of the training, 65 staff members of 36 day care centers were trained to use the titmus machine, fly chart and pure tone audiometer in four workshops. These centers/nurseries represented a cross section of operational types. However, the majority were non-profit centers. These non-profit programs were operated by community organizations, city agencies, church affiliates, the local community college and university, the Housing Authority of

Baltimore City, Inc., Head Start and a major medical institution. This participation by a high percentage of non-profit programs is reflective of the overall distribution of operations in the city.

Each workshop was conducted for three and one half hours, including a practice time. Because the training was offered in a child care center, the atmosphere was less formal than in an actual classroom, making the learning situation more comfortable and lending itself to individualized instruction as needed. 65 staff members from 36 centers were trained; of those, 13 centers actually requested the equipment and screened their children for possible vision and hearing problems. All persons requesting the equipment were observed by the Division Nurse or Audiologist in a testing situation to insure accuracy of screening technique and test results.

In an effort to obtain data to support the program, determine its effectiveness and provide referral, the participating centers were requested to furnish the Division with a summary of screening results, a copy of which follows.

ATTACHMENT II

"WE'RE IN YOUR NEIGHBORHOOD"

1982

Dear Director,

We are pleased that you have participated in our self-help screening effort, and have screened the children enrolled in your center for hearing and vision problems. We are interested in obtaining information that will enable us to ascertain the benefit and effectiveness of this program.

Therefore, we are requesting that you complete the form below and return it when you return the equipment.

We will be contacting you in several months to obtain information on the followup of children who did not pass a screening.

If you have any questions, please feel free to call Judith Young at 396-4465.

Thank you.

Sincerely,

Brenda B. Coakley
Chief, Division of Child Day Care

Debra Sterling
Audiologist, Bureau of School Health

_____

Name of Center: _____ Contact Person
Address _____ Persons(s) Screening
Telephone: _____
Date(s) of Screening:
No. of children screened: Hearing ____ Vision ____
No. of children who did not pass a screening:
Hearing _____ Vision _____

A total of 676 children received screenings (out of approximately 750 enrolled). Of those screened, 47 were positive hearing screenings and 32 were positive vision screenings. Parents of these children were notified and advised to contact the family health care provider for follow-up or further testing.

The second year the child day care programs were polled again to determine the necessity of continuing the training. Fifteen centers indicated a desire to participate; five of which had originally participated. Seventeen individuals and an additional six Health Department staff completed the training during one workshop session.

During the third year, seven of the 15 day care centers with trained staff who were at the spring workshop requested the hearing and vision equipment. Four centers returned the statistical data indicating:

105 children receiving vision screening
—26 not passing

165 children receiving hearing screening
—19 not passing

The equipment, on permanent loan to the Day Care Division from the Speech and Hearing Division, is continuously available for the day care centers to borrow for screening purposes. The availability of the equipment is periodically announced in the quarterly Division Newsletter and workshops are scheduled upon demand.

The overall reception of this "self-help" project was positive and continues to be utilized. However, lack of cooperation in obtaining data from the centers resulted in insufficient information for planning and projection purposes. The current method of collection requires the data to be submitted when the equipment is returned. Increasing the participant's understanding of the need and use of data gathering might be stressed in the workshops, thereby resulting in better data collection.

Vital to such a program is the availability of equipment. Adequate quantities of equipment, which could reduce waiting periods for the loan, would in effect keep interest in the service heightened. Related to the availability of equipment is a plan for maintenance. The Day Care Nurse Coordinator was responsible for the initial check in of equipment for determining proper repair and functioning. However, callibration and cleaning and repair, if necessary, were performed under outside contract at another city location/agency. This delay can result in waining interest, thereby excluding some children from a valuable preventive service.

Despite these problems, the value to the children and day care centers is immeasurable, and the cost effectiveness of the project is obvious. Had the vision-hearing testers performed screenings of the same population, the Department's cost would have been $1,486.46, including fringe benefits. By training the day care center/day nursery staff to perform the screenings, the cost was reduced to $788.22 during the first year of the project (See Table I). Subsequent years' cost for the project decreases even further because only the newly trained staff receive monitoring in the testing technique and use of equipment, and initial costs to project preparation are eliminated.

TABLE I

Cost of Training Day Care Personnel
to Perform Vision-Hearing Screening

	Hours	Nurse @7.35*	Audiologist @8.45**	Total
Instructor Preparation	3	22.05		22.05
Pre-implementation (4 Workshops @ 3.5 hours per	3	22.05		22.05
Training Instruction (4 Workshops @3.5 hours per	14	102.90	118.30	221.20
Travel to Workshops (4)	2	14.70	16.90	31.60
Transportation Cost @1.20		4.80	4.80	9.60
Monitoring/Follow-up***	27	198.45	228.15	426.60
On-site (per center)	3.5	25.72		25.72
Scheduling of Equipment & Maintenance	4	29.40		29.40
		420.08	368.15	788.22

On-site (36 Centers)
Nurse—18 centers x 1.5 hours (at each center) = 27 hours.
Audiologist—18 centers x 1.5 hours (at each center) = 27 hours.

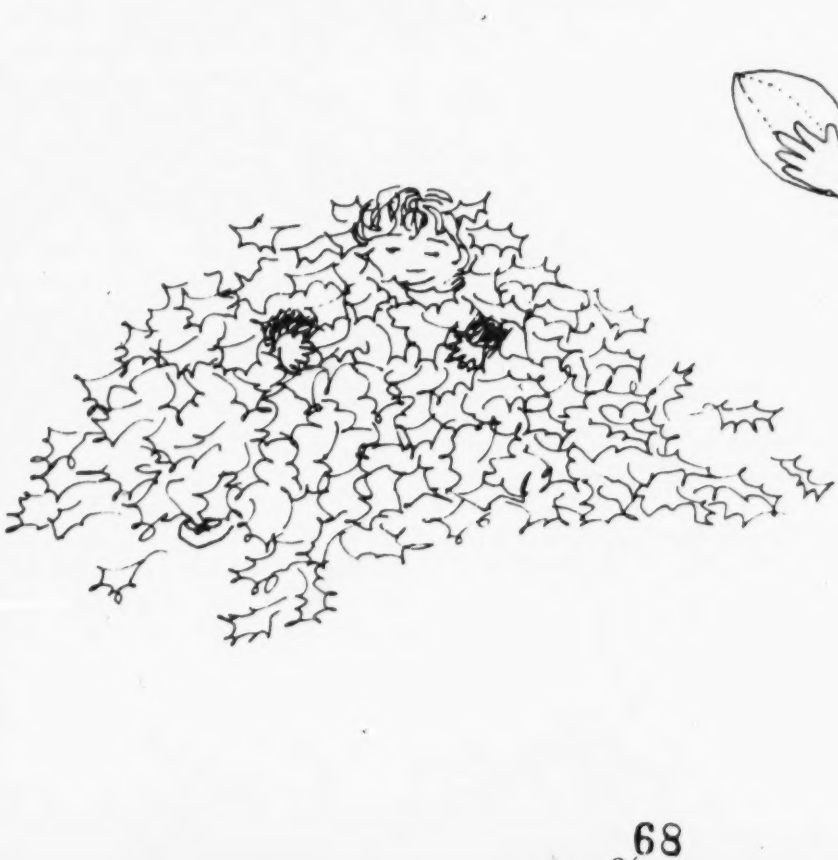
*Cost figures involve actual salary, not including fringe benefits, which would total 18.5%.

**Note: This figure does not include equipment or replacement costs.

***Monitoring

As a result of this project there is a cadre of trained day care personnel available to screen the child day care population. A total of 82 staff were trained, 920 children were screened for vision acuity and muscle balance problems, and 970 children were screened for hearing loss during the first three year period. If the goal of public health is the maintenance and improvement of the health of all the people by combining the sciences, our skills and beliefs, preventive medicine must then be our primary objective.

In an era of apparent dwindling resources, we as public health professionals are challenged, perhaps as never before, to creatively use our existing resources, discover new and better ways to stretch dollars, yet continue to maximize service delivery to an ever increasing child care population. This project combined existing resources within the Health Department and community to provide a cost-effective needed preventive health service. Early detection of vision and/or hearing impairments is not only beneficial to the child but to society and the community as well. A healthy, well developed child grows into an educated, productive, responsible citizen. Public health's contribution to this individual and society is revealed in the child's readiness for school and success in school by virtue of preventive health programs.



Building partnerships in the professional community

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ABSTRACT

When the Day Care Enrichment Program of the City of Dallas established a partnership with the Dallas Independent School District, the Dallas County Mental Health and Mental Retardation Center, and 35 other smaller agencies providing services to developmentally delayed children in Dallas County, the program was able to increase its existing service delivery. It became capable of screening preschool children enrolled in day care centers for potentially handicapping conditions including speech, development, vision, hearing and behavior problems. The partnership also improved the communication between agencies, decreased "turfism", and established a formal agency network. The Day Care Enrichment Program also formed a partnership with the University of Texas Health Science Center at Dallas' Southwestern Medical School to study Haemophilus influenzae type b infections in day care settings. Sixty day care centers and 32 family day homes participated in the study. The alliance also established a consultation resource between the two agencies and helped to initiate an on-site Rifampin chemoprophylaxis treatment program in day care centers.

BUILDING PARTNERSHIPS IN THE PROFESSIONAL COMMUNITY

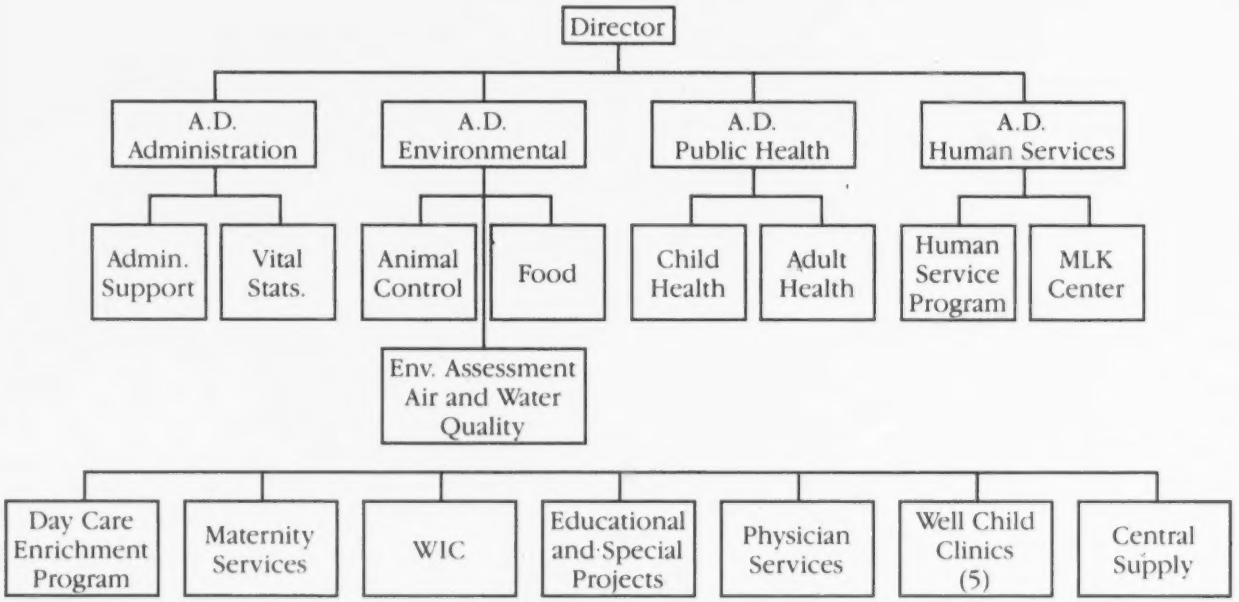
Located in northeastern Texas, the large metropolitan city of Dallas has a population that has grown from 904,078 in 1980 to an estimated 983,851 in 1986. Dallas is perceived locally as being part of the "Metroplex"—a large geographical area that includes Fort Worth and the smaller surrounding municipalities. According to the 1980 census data, 1,404,104 children living in Texas were under the age of six. By 1990, it is estimated that that figure will increase to 2,011,216. In 1980, in the Dallas-Fort Worth area alone, 59.2% of all women were a part of the work force, while 54.1% of that group had children under age six. The median household income in 1980 was $18,853 ($8,465 per capita) with 7.4% of all families surveyed having incomes below the poverty level.

Dallas has a City Manager form of government with 23 departments in the organizational structure. A Public Health Division exists within the Department of Health and Human Services and is divided into a Maternal/Child Health Section and an Adult Health Section. The Day Care Enrichment Program is a specialized program within the Maternal/Child Health section. Table 1 illustrates the organizational structure.

The Day Care Enrichment Program is staffed by four nurse practitioners, two licensed vocational nurses (LVN), one supervisor and one secretary. Services are provided to both day care centers and family day homes located within the city limits of Dallas. The

TABLE I

CITY OF DALLAS
Health and Human Services
Department Structure



nurse practitioners and LVNs have distinct responsibilities in service delivery. The nurse practitioner staff is responsible for handicapping conditions screenings, behavior management classes for caregivers, and parent classes. The LVN staff provides immunizations, manages the communicable disease component of the program, trains caregivers in CPR and first aid, provides health services for day care center staff, and presents health education/in-service programs for children.

The City of Dallas has 347 licensed day care facilities with a combined capacity of 58,196 children. There are 780 registered family day home providers with an undetermined capacity and an unknown number of non-registered providers. Day care facilities are regulated by the Texas Department of Human Services.

The Day Care Enrichment Program has a collegial relationship with the regulatory agency serving as a resource on health issues, especially communicable diseases; training licensing representatives; and participating on task forces that explore day care issues, i.e. safe transportation of children or dealing with hazardous environmental situations (explosives, chemical spills, etc.) in the day care centers.

In order to foster the mission of the Day Care Enrichment Program, several "partnerships" have developed over the past several years. This paper will describe the process of building these partnerships with other health care providers and professionals located in Dallas County. There will be two areas of focus: 1) the partnership established with the Day Care Enrichment Program and the Dallas Independent School District (DISD), the Dallas County Mental Health and Mental Retardation Center (DCMHMR), and 35 other smaller agencies; and 2) the partnership established between the University of Texas Health Science Center at Dallas' Southwestern Medical School and the Day Care Enrichment Program.

STEPS OF IMPLEMENTATION

In 1982, the head of the Early Childhood Program for The Dallas Independent School District desired Early Childhood Intervention funds from the State of Texas. However, state law restricted The Dallas Independent School District to providing services only to developmentally delayed children age 3 or above, while the Early Childhood Intervention funds targeted service delivery for developmentally delayed children ages 0-3. The School District wished to provide services to the 0-3 age group but, at the same time wanted to minimize duplication of services and competition of funding among the other 0-3 providers in Dallas County. The Dallas Independent School District identified the three largest providers of health care delivery to developmentally delayed children as the City of Dallas Department of Health and Human Services, the Dallas County Mental Health and Mental Retardation Center, and the Dallas Independent School District itself. A network of 35 other smaller agencies providing similar services were also identified.

The Dallas Independent School District called an initial meeting of this group of providers. The network of agencies formed became officially known as the Early Childhood Interagency Council of Metropolitan Dallas. After numerous meetings, the Council reached

consensus on three main issues: agencies would not compete against each other for funding, agencies would support each other in grant applications by submitting a group letter of support, and most importantly, the group would decide which agencies would apply for the 0-3 funding.

Since the Day Care Enrichment Program was already providing services to preschool children attending day care in the city of Dallas, a group of 0-3 aged children was easily identified for testing. Thus, it was decided that the Dallas Independent School District and the Dallas County Mental Health and Mental Retardation Center, as well as some other smaller agencies, would apply for the funding and that the DCMHMR would contract with the Day Care Enrichment Program to screen children for potentially handicapping conditions. The initial focus group of the screening was children ages 0-3 but older children were also screened. The contractual agreement allowed the Day Care Enrichment Program to add three nurse practitioner positions to the program and paid for base salaries, fringe benefits, vehicle reimbursement, and postage/paper supplies. The remaining funding for the program was provided through general fund dollars.

The Day Care Enrichment Program also initiated weekly staffings attended by representatives of the Dallas Independent School District, the Dallas County Mental Health and Mental Retardation Center, Child Guidance and the private agencies in the Early Childhood Interagency Council network. The purpose of the staffings was to review the results of the screenings by the Day Care Enrichment staff to determine the most appropriate diagnostic and treatment source in Dallas County. The staffings also provided a monitoring system to assure that the best referral source among a variety of agencies could be located for each child.

The other established partnership focused on communicable disease service delivery. In 1982, a physician in the Department of Pediatric Infectious Diseases at Southwestern Medical School contacted the Day Care Enrichment Program to request assistance with a two year study involving Haemophilus influenzae type b infections of children enrolled in day care centers. The physician needed a way to access the day care centers and knew that the Day Care Enrichment Program was well known in the day care community and was actively involved in monitoring communicable diseases in the day care setting.

The Day Care Enrichment Program staff assisted the physician in obtaining the cooperation of day care centers to participate in the study, delivered information concerning the study, and collected attendance records. The study had a two year enrollment period with a six month follow-up period and is now in the analysis stage for the 60 day care centers and 32 family day homes. Another effect of the partnership has been the implementation of an on-site Rifampin prophylaxis treatment program for day care center contacts of Haemophilus influenzae type b infections. This on-site treatment program was started in 1984 and is another example of how partnerships can expand existing services.

STRENGTHS OF THE PROGRAM

The strengths of the partnership with the Dallas Independent School District, the Dallas County Mental Health and Mental Retardation Center, and the 35 other agencies include: 1) the provision of an interdisciplinary staffing approach in linking each child with the best possible referral source; 2) having the interdisciplinary experts assist in accessing the "system" if there is a breakdown in the referral process; 3) the building of a network of agencies for developmentally delayed children that allows easy phone access for one-to-one consultation on problems; and 4) the establishment of the Early Childhood Interagency Council of Metropolitan Dallas for coordination of funding, service provision and program support, in-service programs, interagency referral and the identification of unmet needs of developmentally delayed children in Dallas County. The bimonthly meetings of the Council allow continuous communication among all the member agencies. Table 2 lists the current agency members.

The strengths of the partnership with Southwestern Medical School include 1) the establishment of a collegial relationship between the Day Care Enrichment Program and the Department of Pediatric Infectious Diseases, 2) participation in research studies, 3) receipt of current information on all communicable diseases applicable to the day care setting, 4) assistance in drafting/updating the exposure notices distributed to day care centers to inform parents of disease outbreaks and 5) the ability to provide an aggressive approach to dealing with communicable diseases in the day care setting. This collegial relationship has been of particular benefit to the Day Care Enrichment Program since at the time the partnership began, both the City and the County health departments lacked a Chief of Epidemiology.

TABLE 2
MEMBERS OF THE EARLY CHILDHOOD INTERAGENCY COUNCIL OF METROPOLITAN DALLAS

- Dallas County Mental Health Mental Retardation Center
- Dallas Independent School District
- City of Dallas Department of Health and Human Services
- Adult Child Training Center
- Education Service Center—Region 10
- Special Care and Career Center
- Garland Independent School District
- Helping Hands Development Center
- Child Care Dallas
- Children and Youth Project
- United Cerebral Palsy of Dallas County
- Autistic Treatment Center
- University Affiliated Center
- Easter Seals
- Richardson Development Center
- Dallas Services for Visually Impaired Children
- ARC of Dallas
- Down Syndrome Guild
- Dallas East Center for Developmental Delay

PROBLEMS OF IMPLEMENTATION

One problem that occurred while building the partnership with the Dallas Independent School District, the Dallas County Mental Health and Mental Retardation Center, and the 35 smaller agencies was the aspect of "turfism." Initially agencies were not communicating with one another because of a fear of too few children for all the agencies to serve. But, because the agencies met collectively and defined their role in service delivery in relation to each other, "turfism" declined. Furthermore, the group discovered that there were more than enough developmentally delayed children needing service in Dallas County. Ironically, it has recently been found that existing service providers are having difficulty providing all the necessary services for children needing services. To alleviate this problem, referrals are being shared between agencies.

The most difficult dilemma of the partnership between the Day Care Enrichment Program and Southwestern Medical School has been the effective communication of treatment recommendations for specific communicable diseases to the day care community. This procedure has proved to be a problem because treatment recommendation follow-through depends on the cooperation of the day care center director, the parents and the primary health care providers of the children. Some primary health care providers do not always understand the implications of communicable disease in the day care setting, i.e. the movement of day care staff from one room to another to care for many different children during the course of a day and likewise, the mingling of children with their own classroom contacts as well as intimate contact with other children on the playground, during eating times, and in the early morning and late evening hours of center operation.

RESULTS

The effectiveness of the partnership is demonstrated by the variety of ways in which children can now be identified for screening:—parent request, day care provider request, and by case finding when the Day Care Enrichment Program staff are in centers providing other services. Additionally, each July all licensed day care facilities in the city limits of Dallas are mailed a brochure describing the services of the Day Care Enrichment Program. Directors or their representatives are invited to training sessions to learn how to utilize an evaluative tool called the PDQ. This tool is used to determine the need for a more detailed developmental assessment. Since it is impossible for four nurse practitioners to screen all children, the tool serves as an assessment that can be given by the caregiver in the day care setting. Using the scoring instructions, the caregiver can then initiate a referral to the nurse practitioner.

After children are referred to the Day Care Enrichment Program, a written parental informed consent is obtained. Consent forms include a

description of screening tests used, prenatal and birth history of the child, and consent to release information between the Day Care Enrichment Program and day care center/provider. Children identified as needing referral after being screened by the Day Care Enrichment Program are staffed at the biweekly meetings. Children are attended by the nurse practitioner until the child has been evaluated by the target provider agency.

During FY 1984-1985, 5,880 preschool children were screened with 389 (7%) referred for potentially handicapping conditions. (There were two nurse practitioner vacancies during this period.) Approximately 10,000 of more than 58,000 day care children are expected to be screened during FY 1985-1986. In addition, the Early Childhood Interagency Council of Metropolitan Dallas has identified the need for more slots in the care of developmentally delayed children in Dallas County. The Council meets annually with state ECI officials to encourage increased funding for the Dallas area.

The partnership with the Southwestern Medical School resulted in the provision of Rifampin chemoprophylaxis to 246 children in five day care centers during the period from April, 1984 to December, 1985. The centers received a treatment recommendation if there were two cases of Haemophilus influenzae type b infection diagnosed within 60 days (American Academy of Pediatrics guidelines).

EVALUATION

The evaluation of the screening program is monitored by the Day Care Enrichment Program's nursing supervisor. Each staff nurse records monthly statistical information on the number of children screened for each condition, the number referred, and the number receiving additional evaluation after referral by the Day Care Enrichment Program. The standards established by the Child Welfare League of America for screenings/percent referrals are used as part of the evaluation of the referral process:

> Standard: 3-5% of all children screened for vision will be referred.
>
> Standard: 10-30% of all children screened for all other conditions (speech, hearing, development, behavior) will be referred.

Screening results are also monitored by the Dallas County Mental Health and Mental Retardation Center. In accordance with the contract, performance measures are established annually identifying the number of children that must be screened for potentially handicapping conditions and the number of day care centers that must receive training in the use of a developmental prescreening tool (PDQ) during the contract year.

The alliance with the Southwestern Medical School has brought about a collegial relationship between the Day Care Enrichment Program and the Department of Pediatric Infectious Diseases, assisted in making important contributions to research, and also increased service delivery in the area of communicable diseases. The Southwestern Medical School also provides consultation and guidance in regard to other aspects of health care within the day care setting.

RECOMMENDATIONS

Public health agencies must take an active role in the provision of health care services for preschool children. The early identification and treatment of potentially handicapping conditions and communicable diseases improves the life-long productivity of the child. Building partnerships in the professional community facilitates information sharing, encourages interagency support, decreases duplication of services, and can provide a mechanism to increase existing service levels at an affordable cost while improving the health and well-being of the preschool child.

The following recommendations are made concerning the development of a program such as the one described in this paper:

1. Identify agencies with common goals to avoid duplication of services. It may be necessary to identify a lead agency in the group to coordinate the meetings and keep the momentum going.

2. Advertise program services using mail-outs, the licensing agency, and day care advocacy groups.

3. Divide the components of the program into distinct job duties for registered nurses and LVNs with overlap as needed for priority issues, i.e. certain communicable diseases.

An integrative approach to child care licensing by a city-county health department

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Child Care Licensing Program

ABSTRACT

The Kansas Department of Health and Environment is the official child care licensing agency in the state.

The Lawrence-Douglas County Health Department is one of 97 local health departments which contract with the state to participate in the licensing program.

In addition to fulfilling the terms of the contract, the Lawrence-Douglas County Health Department has strengthened child care licensing in Douglas County by taking an integrative approach to the provision of regulatory and education services both within the Department and in the community. Child care licensing staff provided the impetus to reduce barriers to licensing. An infectious disease epidemic was managed effectively and health and safety promotion has been strengthened by using the expertise of public health professionals.

DEMOGRAPHICS

Located in the northeastern section of the state, Douglas County has an unusual mixture of small farming communities, educational institutions and numerous light manufacturing industries which provide economic diversity.

The 1980 Census provided the following information:

Total Douglas County population—67,640[1]

Population of incorporated cities:
- Lawrence—54,307[1]
- Eudora—2,968[1]
- Baldwin—2,829[1]
- Lecompton—576[2]

Per capita income—$6,473

Female householder/no husband present with children under 18—1,020

Preschool population (under 5)—4,117

Lawrence, the county seat, is the home of the University of Kansas and Haskell Indian Junior College. Baker University, a private Methodist college, is located in Baldwin. The low median age of 24.41[1] is attributed to the large number of college students residing in the county.

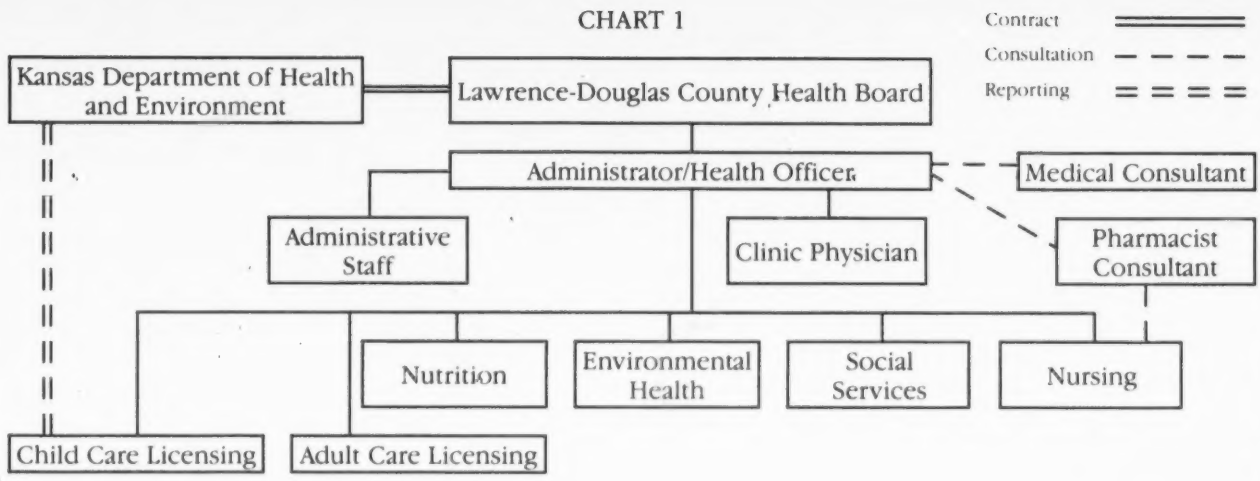
INTRODUCTION

Child care has been regulated in the state of Kansas since 1919. In that year, legislation was enacted which placed the licensing responsibility for all out-of-home care with the state public health department. Subsequent licensing standards have established pat-

[1] *1980 Census of Population, Volume 1 Characteristics of Population, Chapter B, General Population Characteristics Part 18 KSpc 80-1B18 Issued 6/1982.*

[2] *Estimated Census, Douglas County, Issued July 1, 1982.*

CHART 1



terns of child care which safeguard the physical, mental and social well-being of children in care away from their parents.

The licensing statutes authorized the state agency to delegate the responsibility for inspecting child care facilities, and as county health departments were established they became the logical designated licensing agents of the state. For the past nine years the Kansas Department of Health and Environment has formalized this relationship by contracting with local health departments to conduct the child care regulatory program at the local level. Funds appropriated by the legislature are allocated to the counties in proportion to the number of child care facilities in the county. County departments entering into the contract agree to perform the following tasks:

A. provide orientation and application packets to new applicants;

B. date-stamp all copies of incoming documents related to child care licensing functions, and immediately transmit applications for license to the Kansas Department of Health and Environment pursuant to Kansas Administrative Procedures Act;

C. review for completeness the licensing forms submitted by applicants and licensees;

D. make initial licensing inspections within four weeks of receipt of application, and follow-up inspections as needed;

E. make relicensing inspections at least eight weeks prior to license expiration date, and follow-up inspections as needed;

F. make complaint investigations within three working days of receipt of complaint;

G. prepare information for enforcement proceedings and appearing as witnesses at administrative hearings.[3]

The Lawrence-Douglas County Health Department is one of 97 county health departments contracting with the state to conduct the child care licensing program at the local level. Chart 1 depicts the organizational structure of that health department and shows the relationship between the state licensing agency and the local child care licensing staff.

The Lawrence-Douglas County Health Department has not only performed the tasks set forth in the contract, but has expanded its role to meet the particular needs of the Douglas county day care community. The expanded role has evolved due to the concern of the Lawrence-Douglas County Health Board for safeguarding and protecting children. It has been made possible by the financial support of city and county government. The cost of the integrated child care licensing program was $33,600 in 1985, of which the Health Department received $3,358 from the State of Kansas for carrying out the terms of the contract. The balance came from the city and county.

There are five categories of child day care regulated by the state, as follows: registered family day care for six or fewer children; licensed day care homes for ten or fewer children; group day care homes for nine to twelve children; and preschools and child care centers for thirteen or more children. Under state statutes registered family day care homes are exempt from routine home inspections by licensing staff, although complaint investigations are authorized. Registered providers submit an annual self-evaluation checklist prior to receiving a certificate of registration. All other day care facilities are inspected yearly to determine compliance with state statutes and regulations.

In the spring of 1986, Douglas County had 43 licensed day care homes, 9 preschools, 11 child care centers, and 130 registered day care homes which provided care for approximately 2,600 children.

Registered nurses serve as the licensing staff of Douglas County. To evaluate child care facilities, a basic knowledge of health information including child development, hygiene, environmental sanitation, communicable disease, nutrition, safety and children's health issues is essential. Since this body of information is included in nurses' training, a registered nurse has excellent preparation for the role of child

[3]*Excerpt from contract, Kansas Department of Health and Environment/Lawrence-Douglas County Health Department, July 1, 1985—June 30, 1986.*

care evaluator.

Orienting a nurse to the Lawrence-Douglas County Health Department child care licensing position takes several months. The health department's orientation schedule includes: (1) review of Kansas Child Care Licensing Laws; (2) review of each regulation booklet (registered day care homes, licensed day care homes and group day care homes, and preschools and child care centers)[4]; 3) emphasis on the rationale for each regulation and how to evaluate compliance; 4) instruction on the use of the licensing evaluation forms and how to determine the recommendation regarding initial or yearly renewal of license or legal action; (5) complaint taking and investigation; (6) orientation to the role of other agencies in the child care licensing process and introduction to contact people in agencies/associations, i.e. city and county zoning offices, local and state fire departments, Social and Rehabilitation Services Area Office, Child Care Food Program sponsors, and child care provider associations.

In addition to being oriented relative to the regulations, procedures and forms, the nurse makes on-site visits with an experienced evaluator until both are in agreement on the items/situations being evaluated. Emphasis on consistent interpretation and application of regulations is of the utmost importance to proper enforcement of the licensing statutes and for maintaining the respect of the day care community.

To ensure proper enforcement of child care regulations, the licensing surveyor must place primary importance on the regulatory function. However, when the licensing surveyor functions as both a regulator and a facilitator/educator, the surveyor and the provider must be clear on what is covered by licensing standards and when the expanded role is being performed.

The following sections of this paper highlight the initiative taken by the health department in resolving local jurisdictional problems which created barriers to licensing and outlines the health education role assumed by the public health staff to enhance the health of children in day care.

LICENSING STAFF AS FACILITATORS

There were five local governmental body agencies involved in the licensing process for providers caring for seven to twelve children: City Planning Commission, Building Inspection Department, Fire Department, City Commission, and Health Department. Child care providers found it difficult to understand and comply with the various regulations, codes and policies of each of these agencies. Of particular concern was the variation in the child/staff ratios of homes caring for seven to twelve children. To resolve the inconsistencies existing between local ordinances and codes, and state child care facility regulations, a meeting to which key administrative decision-makers involved in the issue were invited, was convened by the health department administrator. Attending were the city manager and city department heads of planning/zoning, building inspection and fire. At this meeting the health department's licensing staff presented the following information: 1) that zoning approval as a step in the licensing process caused delays that unnecessarily limited the provision of day care; 2) that the costs involved in meeting the zoning requirements were a further deterrent; and 3) that licensing requirements should be accepted as ensuring the health, safety and welfare of children attending day care facilities. The administrators present were advised that unless local codes were compatible with state licensing requirements, Lawrence child care providers would be required to seek variances to allow them to care for the number of children allowed by the state. For example, a variance request would have to be filed if the provider wished to care for school age children before and after school, on school holidays, or during the summer months, even though this care was permitted by state regulation. The anticipated increase in workload and the frustrations resulting from the requests for variances was pointed out to city staff.

After the initial meeting at which the key administrative heads were informed of the issue and the need for change, the licensing staff took the issue step by step through the resolution process with the Uniform Building Code Board of Appeals, the City Planning Commission and the City Commission—a process which took approximately three months. The local day care home association was kept informed and provided support at each step. Through the cooperation of all involved, local ordinances and codes regarding child ratios were made consistent with state regulations. In addition, the number of governmental agencies involved in the licensing process was reduced from five to two (health department and fire department). As a result of these changes, providers and child care licensing staff have found the licensing process to be much less complicated.

LICENSING STAFF AS EDUCATORS

Three specific areas of education are provided by the Lawrence-Douglas County licensing staff in support of the health of children in day care: 1) assistance with regulation compliance; 2) health and safety promotion; and 3) parent education.

1. Assistance with regulation compliance

Helping prospective child care providers to understand licensing procedures and regulation is one of the primary education roles of the licensing staff. For child care providers to maintain regulatory compliance, they must understand and internalize the rationale for the regulations. As an initial step in achieving this goal, preapplication meetings are held to offer information to individuals interested in becoming registered or licensed child care providers. Forms and

[4] *Kansas Department of Health and Environment Regulations for Licensing Day Care Homes and Group Day Care Homes for Children; Kansas Regulations for Licensing Preschools and Child Care Centers; and Procedures for Registering a Family Day Care Home.*

regulations are reviewed and the legal ramifications of non-compliance with licensing regulations are discussed. The importance of child safety is stressed, and prospective providers are given information on where to obtain required safety equipment such as child-proof latches, trigger locks, and guards for stoves and stairs. Other topics included at the preapplication meeting are: 1) accepted discipline practices; 2) appropriate program activities and equipment; 3) the responsibility of child care providers in assuring that children in care have health assessments and current immunizations; 4) emergency care forms and procedures required by the local hospital; 5) safety regulations relative to transportation and swimming pools. By the end of the preapplication meeting the prospective applicants should have sufficient information to determine whether or not they wish to become child care providers.

In addition to the preapplication meetings the licensing staff assists the providers in understanding and applying the regulations during on-site facility visits, phone calls and presentations to providers' associations.

Since licensing regulations require compliance with local procedures, the staff has assisted day care providers by contacting businesses/agencies to collect resource information. For example, staff consulted with the local hospital administrator to discuss "Emergency Care" procedures required by the local hospital. That information is now given directly to the day care facility by the licensing staff thus eliminating the necessity for each of the providers to deal individually with the hospital.

2. Health and safety promotion

A second education role of the licensing staff is the on-going promotion of health and safety in day care facilities. Techniques used to accomplish this purpose include: 1) providing pamphlets and other literature on child health and child care issues; 2) keeping provider informed about well child assessments and immunizations offered by the health department; 3) assisting in the development of guidelines for providers to use in determining if a child is ill and when the child should see a physician; 4) teaching providers how to determine and report child abuse, how to evaluate injuries and how to approach parents who do not seek medical care for their children; 5) helping providers to be alert to safety hazards in the play area and the facility, i.e. problems associated with normal deterioration of playground equipment, uneven ground, stairs without railings, paint deterioration, etc.; 6) explaining the importance of storing and administering medications properly; 7) offering training on infectious disease including the disease transmission process, how to prevent the spread of infectious diseases, and proper handwashing techniques. As an example of the health department's role in the control of infectious diseases in day care, when outbreak of giardiasis continued to occur in child care facilities for eleven months during 1982-83, consultation was sought from the Centers for Disease Control. A study was undertaken with input from providers, parents and licensing staff. The health department's Communicable Disease Charge Nurse compiled the information and developed a Giardiasis Manual including a record keeping system.[5]

3. Parent education

The licensing staff have educational materials available for parents regarding the different types of child care facilities and how to choose a child care provider. With this information parents are able to make informed decisions regarding child care for their children. In addition, a list of registered/licensed providers is available to the public. The staff maintains office hours to be available for phone consultation and to return calls when messages are left at the health department.

EVALUATION

The Lawrence-Douglas County Health Department believes that the strength of its licensing program lies in the fact that the broad spectrum of public health is an integral part of the licensing program. All professional interests represented on the health department staff serve as a resource to the licensing staff, providers and parents, contributing expertise in the areas of health and safety, sanitation, nutrition and communicable disease control.

RECOMMENDATIONS

The Lawrence-Douglas County Health Department is a strong advocate for public health involvement in the child care licensing process. The health department recommends that licensing agencies work in cooperation with other governmental agencies who affect child care facilities so that regulations, ordinances and codes are consistent and compatible.

[5] *Lawrence-Douglas County Health Department, Lawrence, Kansas* Giardiasis Manual Detection and Control in Child Care Facilities, 1984.

Child care and public health in Marin County

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ABSTRACT

Marin County, north of San Francisco across the Golden Gate Bridge, is developing a network of collaborating agencies to improve the health of children who receive child care services. This effort facilitates the working together of multidisciplinary persons and agencies toward common goals. Public Health staff actively participate in advancing the health and safety of children in day care settings.

The Child, Adolescent and Parent Health Board (CAPHB) has been functioning since 1982 to improve collaboration and coordination among those persons and agencies concerned with maternal and child health in Marin County. The Board is advisory to the Health Council of Marin (HCM), the Department of Health and Human Services (DH&HS) and the County Board of Supervisors (BOS). The CAPHB is made up of representatives from the following areas: private pediatricians, Kaiser-Permanente Medical Group Pediatricians, parents, preschools, child care centers and homes, social services, mental health, drug and alcohol services, adolescents, the disabled community, blacks, hispanics, southeast asians, education, school nurses, obstetrics and gynecology, and the Health Council of Marin. A representative from the Family Practice Physicians is currently being considered as well.

The CAPHB Day Care Committee includes representatives from Social Services (including Family Day Care Licensing), local day care centers and day care homes, the Resource and Referral Agency, private pediatric care providers, parent groups and public health personnel including pediatric, public health nursing, health education and nutrition. Priority concerns include communicable diseases, safety, nutrition and child abuse prevention.

INTRODUCTION

Marin is a county of 257 square miles and of temperate climate. Most of the population lives along the main north-south highway, Route 101, in the eastern section. The western area, hilly and rural, borders on the Pacific Ocean.

Marin County's population remains fairly stable (224,000) although the median age has increased from 29.5 years in 1970 to 33.6 years in 1980. A large percentage of the population is comprised of well-educated, professional people with relatively high incomes. In 1984, the median income was $21,311 while married couples earned an average of $39,904. 38% of the population had attended four or more years of college.

Of the total population, 28% is 21 years of age or under. Almost 5% is under the age of five. 24% of all families are headed by a single parent and 57% of all women with children work outside the home.

In 1980, over 6300 full time child care spaces were needed. These were handled by 192 Family Day Care Homes and 136 Child Care Centers. Over 850 children were assigned to a waiting list for an average

of five to nine months. 33% of all day care requests came from low income families while 50% came from single parents. Unfortunately many of the services available were also expensive. In a child care center, costs ranged from $325 to $443 per month, while a family day care home charged from $338 to $388.

Licensure and monitoring responsibilities for centers are under State Social Services direction. Family Day Care Homes are licensed and monitored by local county staff in Social Services as part of the Department of Health and Human Services. Public health and medical consultation are provided informally by PHN's and the Assistant Health Officer for Child Health Services (AHO/CHS).

A coordinating Resource and Referral agency (Project Care) works cooperatively with the individual child care progams and the Family Day Care Association. A bimonthly newsletter is published; orientation and training programs are regularly provided.

PUBLIC HEALTH/PRIVATE PEDIATRIC CARE

An Assistant Health Officer for Child Health Services (AHO/CHS) supervises the children's health programs and works closely with the Public Health Nurses (PHN). The above persons also consult with Social Services programs such as Child Protective Services (CPS), Medi-Cal and Foster/Adoption placement services. Child Health clinics provide well-child care to young children from low income families. There are thirty pediatricians in the County, all of whom accept Medi-Cal (California MediCaid), Child Health and Disability Prevention (CHDP) (California EPSDT) and California (Crippled) Children Services (CCS) payment. There are eight other pediatricians associated with the Kaiser Foundation Hospital (Permanente Medical Group-PMG), a prepaid Health Maintenance Organization (HMO) in central Marin County.

CHILD CARE/PUBLIC HEALTH

Many public health issues such as infections, accidents, child development and others have been identified regarding child care settings throughout the world. Medical support for children in such settings in Marin County has been limited to input from personal physicians and the traditional public health involvement, e.g. infectious disease outbreaks. Child care program operators noted the dearth of regular and generalized support from health professionals. When, in fact, several physicians became involved in localized situations, medical advice was not timely and was often conflicting.

As the demand for child care increased, the health issues multiplied and became more critical, e.g. hepatitis, H. influenzae, child abuse, child passenger safety. Project Care, day care operators, parents, PHNs and physicians identified the need for more formal prevention and health promotion activities, and for better ways to address illness; concerns arising from normal and delayed development; and injury and child abuse. It became increasingly important to establish a more responsive system for coordination among the many people and agencies involved in child care services.

STEPS OF IMPLEMENTATION

Changes in state and local policies since the late 1970s contributed to the coordination of Maternal, Child and Adolescent Health programs among themselves and their integration within the community.

LOCAL PROGRAM COORDINATION

Almost all of the Maternal and Child Health/Crippled Childrens program staff are located in adjacent office space within the County Civic Center building. This has facilitated frequent contact among personnel from related programs. Since 1984, program supervisors have met monthly to update each other regarding activities and to discuss how to improve working relationships for the benefit of clients and office efficiency. The programs represented include Maternal and Child Health, Vital Statistics, Family Planning, Women, Infants and Children Supplemental Food Program (WIC), Public Health Nutrition, Child Health and Disability Prevention, California (Crippled) Children Services, Health Education, Child Health Clinics, Immunization Program, Public Health Nursing, Social Services and Community Mental Health.

LOCAL PLANS

In 1981 state MCH/CHDP agreed to require county program plans as prerequisites for state funds each year. The California Conference of Local Directors for Maternal, Child and Adolescent Health (CCLDMCAH) participated in this decision and associated discussions. Each year, Marin County staff develop a plan which describes their specific goals, objectives, activities, time schedules and evaluation methods in addition to the regular activities required by State/Federal laws and regulations. This "scope of work" is reviewed during the monthly staff meetings to assess progress and to modify as appropriate.

LOCAL PUBLIC HEALTH NURSING

Public Health Nursing has for years been very active within the community. In the early 1980s, PHNs began to receive more frequent requests for assistance in child care related matters. Initially, individual needs were handled as part of an already expanding caseload. However, as these requests increased, the widening spectrum of public health issues became more and more evident. It also became clear that there were general issues, e.g. safety, hygiene, etc., raised by child

care settings that should be addressed by qualified health professionals. Budget requests for a PHN specifically connected to child care programs were denied. However, a PHN was assigned to provide daily consultation to a Social Services placement facility for young children. More recently, a similar request has been made for PHN involvement in a facility for adolescents.

During this time (1983-5) the Child Health Clinic (CHC) population was decreasing. This enabled the part time reassignment (in 1985) of the Pediatric Nurse Practitioner (PNP) to a child care public health coordination/consultation role. The PHNs also began to devote more time and energy to specific child care program involvement. Coordination meetings began with the PNP and Project Care. Letters from the PHNs were mailed to child care operators to introduce themselves and to encourage use of the PHNs as consultants and supporters.

LOCAL ADVISORY BOARD

During the late 1970s, California formulated the Child Health Initiative to improve public access and services to MCH programs. One result was the formation of state and local Maternal, Child and Adolescent Health Boards (CAPHB in Marin County) beginning in 1982. Also, in 1978, California voters passed Proposition 13, and the county government financial limitations that resulted led to the combining of all MCAH related programs in Marin County under the direction of a single Assistant Health Officer. There has been a gradual expansion of interaction among Public Health staff, Social Services and Community Mental Health (CMH) staff, e.g. CPS, Medi-Cal, and other community agencies and programs.

When the CAPHB was formed in 1982, specific effort was made to obtain representation from the health, education and child care communities. In 1984, the Board set day care health issues as its major priority. It was felt that this issue involved most members on the Board and their represented groups, and related to many other health concerns for children in the community. At the time of this decision, several local child care issues had increased in prominence, especially outbreaks of gastrointestinal diseases, H. influenzae invasive disease and child abuse reports associated with day care settings.

The CAPHB established a Day Care Committee to identify goals, objectives, activities and participants. This plan was developed by February, 1985. The committee continues to meet bimonthly to monitor the progress and to make modifications as needs and resources are identified. The goals and objectives are as follows:

GOAL I: Health service consultation should be available regarding all children in day care centers and family day care homes.

OBJECTIVE 1: All known day care providers will have information regarding available physician/PHN services for children under their care.

OBJECTIVE 2: Obtain PHN position in Department of Health and Human Services for consultation to day care providers.

OBJECTIVE 3: Health care issues related to day care will be identified and discussed at community meetings. Each of the following to hold one such meeting:

(a) In-service trainings for PHNs, physicians.

(b) Presentations by health professionals to appropriate groups, e.g. CAPHB, parents, day care providers.

(c) At least two meetings to address day care for mildly ill children.

OBJECTIVE 4: To offer to day care providers information regarding child development issues and milestones based on provider identified needs and concerns.

OBJECTIVE 5: Develop a committee report on current needs and existing day care services for children with disabilities.

GOAL II: Health related information should be available to day care providers, parents and physicians and other health care providers to enable appropriate preventive and treatment services to these children.

OBJECTIVE 1: All known day care providers, parents and primary care physicians will receive information regarding health care of children in centers and homes. Focus will be on day care providers with children under two years of age or in diapers.

OBJECTIVE 2a: Parents will be offered a minimum of two parent education contacts per year. Health education areas to include, but are not limited to nutrition, general health, medicines, hygiene, mental health, dental.

OBJECTIVE 2b: Day care personnel will be provided with information regarding ethnic child rearing practices and health care practices.

OBJECTIVE 3a: Information about infectious diseases in day care settings will be available to day care providers.

OBJECTIVE 3b: Information will be made available to providers regarding storage, administration, side-effects, etc. of medications.

OBJECTIVE 4: Information about physical and sexual abuse of children will be available to day care providers.

OBJECTIVE 5: Educate day care providers so they can recognize types of emergencies and perform appropriate procedures.

STRENGTHS OF PROJECT

Several aspects of this collabortive approach have contributed to its success:

A. The CAPHB is established by state law, giving credence as to its viability to the Board of Supervisors (BOS).

B. The CAPHB members are leaders in the community in their respective fields of representation.

C. The CAPHB members represent the entire broad field of MCAH persons in the county, so both county government personnel and the public feel that the interests of parents and children are well represented.

D. The CAPHB is part of the Health Council of Marin (HCM), formerly the Marin County branch of the now defunct West Bay Health Systems Agency (HSA). The HCM is advisory to the Board of Supervisors on all areas of health, mental health and social services. The association between the CAPHB and the HCM adds further credibility to the recommendations of both advisory groups.

E. The coordination and cooperation of public health persons with the other principals involved in child care means that all the issues are broadly and completely considered and the subsequent recommendations have the support of all appropriate parties. Furthermore, the interaction among the participants has led to better cooperative efforts in other areas besides child care.

F. The use of the Public Health Nurses to address the multiple needs of child care programs and families has many benefits. Assistance is provided in areas such as communicable diseases, general and specific health problems, child abuse, child development, etc. Referrals are made for medical, dental and social problems, and the PHNs serve as vital liaisons among the child care program operators, parents and physicians.

PROBLEMS OF IMPLEMENTATION AND HOW ADDRESSED

Potential problems have been resolved by successful communication and cooperation among the participants and the consequent establishment of trust.

There were concerns and uncertainties among the agencies regarding their respective roles in the committee's efforts. MCAH staff talked with the members and facilitated the committee meetings. The initial focus on mutually acceptable goals helped to promote cooperative efforts, a sense of trust and a willingness to share information and ideas.

The role of a general medical consultant to child care programs was problematical because of liability and funding issues. This matter was discussed during consideration of using private pediatricians in such roles. The use of the PHNs and the AHO/CHS as the advisors and liaisons with the community physicians and child care program operators has been very successful.

The private pediatricians and the pediatricians associated with the PMG (Kaiser) have had little interaction and are competitive for a limited pediatric population. Both groups have cooperated fully regarding the child care efforts and have also worked very closely together with the AHO/CHS in a related area, i.e. establishment of a medical evaluation system for child sexual abuse victims.

Unlicensed day care programs are not being directly addressed except by "word-of-mouth" among providers and informal consultation by Project Care and Public Health Nurses.

RESULTS

The Day Care Committee of the CAPHB finalized its goals, objectives and activities in December, 1985. Several of the activities have already been implemented and further meetings and programs are planned. Examples of public health involvement in child care include:

A. Emergency care pamphlets have been developed by public health educators, Project Care and county MCH personnel, and have been distributed by Marin Social Services to all day care providers.

B. Public Health Nurses and the nutritionist have written articles for the Project Care newsletter.

C. Public health staff participated in a conference presented to parents and child care providers regarding infectious diseases. Other presenters included private and PMG pediatricians and the President of the Day Care Association. Topics included a description of types of illnesses in day care, general prevention and management of ill children, and characteristics of specific diseases.

D. The Project Care Director, pediatricians and representatives from County Special Education are participating in a Pediatric AIDS Task Force coordinated by the AHO/CHS and the Communicable Disease PHN liaison. A County Office of Education procedure has been written, distributed and discussed with district superintendents. A policy is being developed.

E. The County Nutritionist provides consultation to the state supported day care centers and has provided in-service education on food allergies (on provider request).

F. A nutrition survey is underway to identify topics for later in-service presentations to operators.

G. A pediatric "Grand Rounds" presentation in the county focused on day care health issues.

H. A district PHN consultation system with appropriate back-up has been formalized and has improved communication among the key parties. PHNs and the PNP attend regional Project Care meetings. In-services are planned to include CPR and SIDS. There is interaction among parents, physicians, day care operators, school nurses, public health nurses, the Communicable Disease PHN and the AHO/CHS. This collaboration has enabled, for example, the smooth implementation of Rifampin prophylactic administration to all children and staff involved in a small outbreak of H. influenzae type B disease. A written protocol for

community management of future cases has been developed and approved by County and primary care physicians.

I. Four or five workshops for parents and day care operators are planned yearly to cover all geographical areas of the county and a variety of child care issues.

J. The PNP and Project Care Director provided testimony to the State Task Force investigating the problem of day care for mildly ill children. The recommendations of the Task Force will be considered by the CAPHB Day Care Committee as part of the Contagious Disease Manual being developed for providers.

K. The CAPHB presented to the Health Council of Marin and County Board of Supervisors.

L. The AHO and Contagious Disease PHN Coordinator provided a presentation to the physician staff at the hospital in the northern region of the county regarding health issues for children in day care.

M. The AHO and Contagious Disease PHN Coordinator participated in a local television presentation regarding child care health issues.

N. County Health Education staff have obtained an Office of Traffic Safety grant aimed at injury prevention for all age groups, including young children.

O. The CHDP Deputy Director provides staff support to the CAPHB and is also a member of the Head Start Health Advisory Committee.

P. The County Health Education staff has developed Early Childhood Developmental Guidelines (ages 0-5 years) for use in public health/community clinics, private physician's offices and CHDP programs. Discussions are underway regarding the usefulness of these materials by day care operators and staff.

Q. A task force of representatives from County Health Services, Social Services (Child Protective Services), community pediatricians, (private practice and Permanente Medical Group), Sheriff, District Attorney and pediatric service hospitals have developed a procedure for referrals for expert medical evaluation of child sexual abuse. This is a county-wide system that facilitates medical referral, evaluation and follow-up as well as child and family counseling, evidence collection and prosecution. Many children who utilize this service are in the preschool population and attend day care programs.

These activities and others have improved the day care operator's awareness and utilization of community resources such as the child passenger safety laws and the car seat loaner program, the Dental Care Foundation for children of low income families, etc.

EVALUATION

In addition to smoother regular interaction among families, providers and health professionals, several specific items will be monitored. Each of the Day Care Committee's objectives has an evaluation component. For example, the quarterly presentations to providers and families will be checked for both occurrence and comments by attendees. Distribution of materials, for example, emergency care booklets, will be verified. Any problems evident during evaluation of infectious disease outbreaks will be examined closely for areas of communication and cooperation that need improvement. The continuity of the committee's meetings will be a sign of continued enthusiasm on the part of the members.

RECOMMENDATIONS

The Marin County Public Health collaborative effort has filled gaps in health services to children in day care settings, avoided duplication and conflicts in service provision and identified ways concerned persons and agencies may better work together to address the many health and related issues that affect these children.

There are certain functions, for example, general legislation, that must be carried out at the state level. The current political climate is in favor of greater assumption of fiscal and administrative responsibility by local government. Resources have become more limited and are expected to become even more scarce. It is crucial that state/local governmental cooperation and coordination take place in order to reach the most appropriate and effective balance in implementing all public health programs, including child care. Similarly, it is of even greater importance that local government work cooperatively with other local agencies and persons. For a variety of reasons, MCAH programs are especially susceptible to loss of budgetary support and general effectiveness. Child care services may be exceptionally vulnerable because of the newness of public-private-social-medical-public health interaction that is necessary and the dynamic nature of all aspects of the field.

Each local area will need to identify the principal parties involved in child care in the region and establish appropriate mechanisms to deal with the myriad of problems that arise. Public Health, and particularly Maternal and Child Health personnel have important roles in this endeavor.

Meeting the health needs of children in day care

A multi-disciplinary team approach

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ABSTRACT

The Minneapolis Health Department provides a broad range of health services to a variety of child care settings in Minneapolis, Minnesota. Services include: nursing, dental, nutrition, laboratory, health education, environmental health, medical, developmental, occupational therapy, and social services. Services are provided by a multidisciplinary team composed of health professionals from the divisions of Personal Health, Nursing and Environmental Health within the Health Department. Public Health Nurses are assigned full time to day care activities and function as coordinators of the day care team for each child care setting served. The program continues to undergo modification in response to the changing needs of child care.

INTRODUCTION

Children in our society are a heterogeneous group with diverse backgrounds and needs. However, there is a general consensus that all children have at least one thing in common: the need to be given the opportunity to optimally develop their physical, intellectual, emotional, and social potential. The care and guidance they receive in their early years of life are of critical importance in fostering this optimum development. For many children, this support is provided in their own homes; but, the increasing number of single parent families and the increasing need for women to work outside of the home has necessitated the development of alternative sources of care for infants, toddlers, and preschoolers. Day care programs are one alternative in meeting this need; and ensuring that these settings are healthy, safe and developmentally stimulating is of major interest and concern for health professionals whose focus is child development and family health.

The expansion of all forms of day care (day care centers, family day care, preschools, and nursery schools) has placed a large number of children in close proximity to one another for a major portion of the day. This increases their risk for developing respiratory, gastro-intestinal and other illnesses. In addition, having children spend extended periods of time in non-parental supervised situations requires that the caregiver have knowledge of a child's existing health problems and the ability to deal with new and existing problems in an effective fashion. A 1981 audit of the health records of 502 children in 11 Minneapolis day care programs revealed that this knowledge is not always present. The audit found that 49% of the health problems previously identified and documented in the day care center's health record were unknown to center staff. This does not even consider the number of health problems that exist but have not been identified.

Similarly a study done by the Greater Minneapolis Day Care Association (GMDCA) revealed that 34.8% of children in day care with previously diagnosed

handicaps and/or developmental delays were receiving no special services in the day care setting. In addition, 12.3% of children in that study were classified as being "at risk" for physical and developmental delays because of environmental, nutritional and family problems and were not receiving special interventions. The GMDCA study also demonstrated that centers providing specialized interventions seldom, if ever, had access to a comprehensive or coordinated range of services that included speech therapy, occupational therapy, play therapy, parent education, nutrition counseling, social work services, dental health education or family counseling.

Given this background, it is obvious that the health service needs of day care are great and that they haven't been adequately addressed. Despite the documented health problems associated with day care, little information is available on how to address these problems in an efficient and effective manner. The American Academy of Pediatrics has urged physicians to take an active role in day care and other studies have identified the public health nurse as an appropriate consultant to day care staff, but these approaches fail to address the unique and diverse skills that are necessary to meet the multiple and complex needs of children in day care.

Because of this, the Minneapolis Health Department has developed a coordinated multi-disciplinary team approach to the needs of children in day care. This model incorporated the services of public health nurses, nurse practitioners, physicians, dentists, dental hygienists, social workers, occupational therapists, sanitarians, nutritionists and health educators. This team provides a broad range of consultative and direct health services in an efficient and effective manner.

SETTING OF THE DAY CARE PROGRAM

Demographics

With a 1985 population of 362,090, Minneapolis is the largest city in Minnesota. Although the total population of the city is decreasing, the number of children under age five has increased from 22,433 in 1980 to an estimated 25,000 in 1985. The 1980 census identified 82,946 family households in Minneapolis, with 61,311 (73.9%) being married couple families and 17,615 (21.2%) having only a female head of household. Of married couple families, 40.4% have children under the age of 18. Of female only headed families, 61.4% have children under 18 years of age.

The 1979 per capita income in Minneapolis was $7,940 and the mean family income for all families was $22,504. The mean income for families with children under age 18 was $21,711. Married couple families had a mean income of $25,313, compared to $13,102 for female only headed households. For families with children under age 18, the mean income was $26,824 for married couple families, compared to $9,950 for female headed families. Female only headed households with children under age 6 had a median income of $5,681 compared to $21,024 for married couple households.

In 1980 there were 164,731 females over the age of 15 living in Minneapolis and 95,486 (58.0%) were in the labor force. Of women with children under 6 years of age 9,802 (53.0%) were in the labor force.

CHILD CARE SERVICES

In 1985 there were 665 licensed child care facilities in Minneapolis with a licensed capacity of 9,666. Among these facilities there were 540 family day care homes, 73 full day child care centers, 39 half-day child care centers, 2 Head Start programs, and 11 public school latchkey sites. There are approximately 30 legally unlicensed day care programs and an unknown number of unlicensed family day care settings. Three day care programs exist to care for ill children.

ORGANIZATION OF THE MINNEAPOLIS HEALTH DEPARTMENT

The Minneapolis Health Department is the official public health agency for the City of Minneapolis. The Department is directed by a Commissioner of Health who reports to a 13 member City Council which functions as the Board of Health and the policy making body for the Health Department.

The Minneapolis Health Department is made up of 4 divisions: Administration, Environmental Health, Public Health Nursing and Personal Health Services. Each is headed by a division director who reports to the Commissioner of Health. Activities related to day care occur in each division. The Division of Administration is responsible for financial management and assistance with program planning and development. This division also facilitates communication between Health Department staff and the City Council.

The majority of Health Department day care activity occurs in the Public Health Nursing Division. In this division there is an official day care team supervised by a Public Health Nurse. She reports to a Clinical Supervisor who is supervised by the Division Director.

In the Environmental Health Division a sanitarian is assigned half-time to day care activities. In the Division of Personal Health Services a variety of health professionals engage in a variable amount of day care activity. Each of these individuals reports to a functional area head who in turn reports to the division director. The activities of the entire day care program are described in this report.

STEPS IN IMPLEMENTATION

For many years the day care consultation activities of the Minneapolis Health Department were informally provided by public health nurses as part of their home visiting and health promotion activities. There was no organized day care program and no specialized staff were available to address the unique needs of day

care programs.

During the 1970's, as the number of children in day care increased, public health nurses with special interest and expertise in the area of day care were identified and a portion of their time was specifically devoted to day care consultation. In August of 1982 the activities of these public health nurses were consolidated into an organized day care team and were given the responsibility of developing and coordinating the day care activities of the Minneapolis Health Department.

While these day care activities were developing, the Maternal and Child Health (MCH) Program of the Minneapolis Health Department was providing comprehensive child health services through a Children and Youth (C&Y) Project supported by Title V of the Social Security Act. These services were provided at clinics throughout the City of Minneapolis by a multidisciplinary team. Services were targeted at low income/high risk children and focused on disease prevention and health promotion services.

Paralleling the experience of the Public Health Nursing Program, the MCH Program recognized the increasingly important influence of day care on the health and development of the children it served. Because of this, MCH Program staff began providing consultation to day care programs on behalf of the C&Y project and ranged from nutrition to social services. Inevitably this consultation extended beyond C&Y registrants and encompassed a broader population.

The Environmental Health Program of the Department has also been involved in day care activities. Because of the relatively large number of children being cared for in one setting and because food is often served, a sanitarian was assigned to provide assessments and recommendations to day care programs regarding a broad range of environmental issues.

Given the long history of collaboration between the various programs within the Health Department, coordination of the multiple day care services has been a logical development. Initially this occurred on an intermittent and informal basis, but with the establishment of the day care team in 1982 the activities of the various providers has been much more organized and systematic. The public health nurses now play a lead role in determining overall program direction and function as coordinators of multidisciplinary health services provided by the health department.

Since the day care program is relatively new, the organizational structure is still in an evolutionary phase. The professionals on the multi-disciplinary team are still learning the best ways to use each other's services and how to best meet the needs of the children in day care programs. As day care gradually moves up in the overall priorities of the MHC, more emphasis is being placed on organizing the overall day care service activities in a way that fosters collaboration and communication among health professionals on the team, and thus enhances the efficiency and effectiveness of the services provided.

The health of children in day care is an issue that is continually changing and rapidly growing in importance. The service providers that are needed to address this issue must be flexible and adaptable if they are going to have a positive impact. The Minneapolis Health Department recognized this situation and has laid the groundwork for a multidirectional expansion of its day care efforts dictated by changing expertise, needs, and resources.

STRENGTHS OF THE PROGRAM

With health professionals from a variety of disciplines involved in day care, a broader perspective on the issues surrounding day care can be obtained. Not only can members of the team use their specialized expertise in dealing directly with complex problems but they can also use this expertise to educate other team members and day care center staff. Some of the services and activities provided by members of the multi-disciplinary team include:

Public Health Nursing—The public health nurses function as team coordinators for each day care center. They plan assessments in the various specialty areas and they work with center staff to identify health needs and coordinate direct and consultative health services for children, their families, and day care center staff. In consultation with the physician and sanitarian, the PHN reviews the policies and procedures of day care centers and makes recommendations regarding safety, emergency plans, and the physical environment. They establish linkages with other agencies that provide health and social services, so that needs can be addressed in an appropriate fashion. They also provide frequent in-service training and continuing education classes for day care workers and others interested in day care issues and problems.

Dental—Under the supervision of a dentist, a dental hygienist provides dental screening services and dental education to children in day care settings. The hygienist also provides education to parents and day care center staff.

Nutrition—A nutritionist provides nutrition assessments, counseling and education to children, parents and day care center staff. Information on the long term benefits of good nutrition is presented. Assessments and recommendations regarding the nutritional value of lunch and snack programs are also provided. The nutritionist makes referrals to community nutrition and food programs such as WIC (Supplemental Food Program for Women, Infants, and Children), food shelves and the Expanded Food and Nutrition Education Program (EFNEP), if needed. A growth monitoring program has also been initiated at two day care centers.

Social Services—A social worker provides assistance to day care center staff and families in working with special needs children and their families. The social worker also facilitates the appropriate use of community social services.

Developmental Services—Appropriate screening

procedures are established and conducted by an Occupational Therapist. The OT also provides consultative services regarding sensory and motor development of children in day care. Direct services are also provided to assess children identified through screenings. Treatment and referral services are provided as appropriate.

Laboratory—The laboratory provides screening tests deemed necessary by the physician and PHN. To date these tests have included blood lead, zinc erythrocyte protorporphyren (ZEP), hematocrits, throat cultures and stool exams for ova and parasites.

Health Education—A health educator develops and delivers prevention oriented health education programs for day care center staff and families of children enrolled in day care. Audio-visual aid and general informational material are also developed by the health educator.

Environmental Health Services—An environmental health sanitarian is assigned the responsibility of inspecting and monitoring day care centers. Physical hazards, fire safety and sanitation are major areas of concern. The sanitarian also works with the nutritionist in educating day care center staff regarding food preparation and handling.

Medical—A physician provides overall medical consultation to members of the day care team. In cooperation with the Public Health Nurse, the physician reviews the policies and procedures of day care centers and makes recommendations regarding the adequacy of the health and safety components. In addition, a pediatric nurse practitioner is available to respond to medical issues raised by members of the day care team.

The direct services provided by the multi-disciplinary day care team have been of great value to day care centers and the children they serve, but the advocacy and linkages that have been developed by the day care team have been equally important. Having individuals from various backgrounds involved in the day care program has fostered linkages with a wide variety of health and social services agencies. As these agencies have become more involved in day care issues, they have become advocates for day care services and have been influential in making child care a high community priority. The multi-disciplinary focus of the Health Department program is one of the reasons for the broad based interest in day care in Minneapolis.

PROBLEMS IN DEVELOPING THE PROGRAM

The health concerns surrounding children in day care are being continually identified and clarified, and being seen as an increasingly important community issue. Because of this, flexibility and commitment by the individuals and agencies providing services to day care are required. The Minneapolis Health Department has not always had this flexibility and commitment and is still far from having a perfect day care program.

However, improvements continue to be made and the program is getting closer to the model that staff see as being best able to meet the needs of children in day care.

The first problem to overcome in becoming a model program was the lack of commitment to day care. Initially, in response to requests from day care centers, several public health nurses were assigned the responsibility of providing consultation to these centers. Each nurse provided services to one or several day care centers in addition to other assigned duties. Although this was the beginning of the provision of services to the centers, delivery was sporadic and inconsistent. Coordination of services was minimal and often educational programs and materials would be developed by one nurse without the realization that another nurse had developed something similar only a short time before.

Service delivery to day care was generally not seen as a priority by nurses if the workload was heavy. Day care tasks were generally the first ones dropped when time pressures became acute. Frustration among the nursing staff was also high because each nurse found it difficult to become adequately informed about the needs of day care when they were serving only a few centers. Similarly some centers became frustrated because services were often inconsistent.

To address this problem the Public Health Nursing Program shifted assignments and concentrated day care activities to a few nurses. They also identified day care as a special unit. Although fewer nurses were involved in day care, each nurse could now focus all efforts on day care and provide consultation more effectively and efficiently to a large number of centers. Identification of a lead nurse for the day care program also facilitated the coordination of day care activities. This commitment to day care was a major step in the development of a high quality program.

Another barrier to overcome in the development of a model program was the lack of coordination of services within the Health Department. Although the first official responsibility for day care rests with the Public Health Nursing Division, many day care services are provided by two other divisions: Personal Health Services and Environmental Health. For many years the day care activities of these 2 divisions interfaced only intermittently with the public health nursing activities.

With the development of the specialized day care team in nursing, it became evident that more coordination and collaboration were needed. Subsequently, regular meetings were established for all staff involved with day care in order to share activities, ideas, and plans. Meetings are also being held routinely between the coordinators of day care activities in each division in order to facilitate the development of mutual short and long range plans.

Although these efforts have done a lot to coordinate day care activities, deficiencies still exist. Having three divisions, and thus three administrative structures and priorities, providing services to day care makes coordination difficult and markedly reduces the flexibility of the program in adequately responding to needs. Because personnel in Personal Health Services and Environmental Health provide services in areas other than day care it is impossible at this time to put all day care activities in one division. Therefore, there are continued efforts to find ways to better coordinate the multiple and diverse day care efforts of the Department.

A major impediment to developing the day care program is the lack of financial resources. Staff from the day care team and staff from the centers have identified a variety of interventions to deal with the problems in day care but often they can't be implemented because of inadequate resources. Funds for staffing came from a variety of sources including: city taxes, Minnesota Community Health Services Act, and the Maternal and Child Health Block grant. Fees for services are charged where possible especially for certification classes for day care center staff. However, because many of the centers serve low income populations, fees for services can generate a limited amount of income. As public funds decrease, the dilemma is going to worsen and may threaten the existence of the day care program and many other public health programs.

RESULTS AND EVALUATION

The impact of the Minneapolis Health Department day care program can be evaluated in a variety of ways. From a numerical perspective the impact has been impressive. Each year over 100 day care programs of various kinds receive multi-disciplinary services from the MHC day care team and approximately 300 group educational sessions are held. These services directly impact over 10,000 children and 5000 parents, day care workers, and health professionals. In addition, the Health Department sends information on health issues in day care to numerous individuals and groups throughout the country.

More importantly, however, are the non-quantifiable aspects of the program. By serving on various boards, committees and task forces, team members have been influential in enhancing not only the development of day care programs, but other programs affecting the health of all children. They have also helped to make child care a high priority issue in Minneapolis.

Some of the major issues that have been directly influenced by members of the day care team include: ill child day care, subsidized day care, licensing of day care centers; and therapeutic intervention for special needs children, child abuse and neglect, and a host of others. In dealing with these issues the members of the day care team have demonstrated their level of expertise to the community and are increasingly being asked to participate in planning, developing, and evaluating programs that have the potential to improve the health of all children in Minneapolis. Because of this, the greatest contribution of the program will be realized in the future with a healthier generation of children.

RECOMMENDATIONS

From the experience of the Minneapolis Health Department in dealing with the issue of the health of children in day care, several observations and recommendations can be made, relative to agencies and organizations servicing day care centers. These recommendations are made not so much to avoid potential problems but to assist programs in more effectively serving children in day care. Some of these recommendations can be taken independently but most are interrelated and part of a comprehensive approach to child care.

Make Day Care a Priority: Although the health of children in day care is an increasingly important issue, many agencies don't recognize this fact in their organizational structure. Day care activities are frequently combined with other activities and are often the first to be affected when time and/or resources are reduced. To decrease this vulnerability, a day care program must be recognized as an independent and vital function of an agency. This can be accomplished by establishing a separate day care program or highlighting, in some fashion, the day care activities of the agency. The more visibility the day care activities receive, the more they will be considered a valuable resource, not only within the agency, but within the broader community. A commitment to child care by one agency will help to stimulate further interest throughout the community in the needs of children.

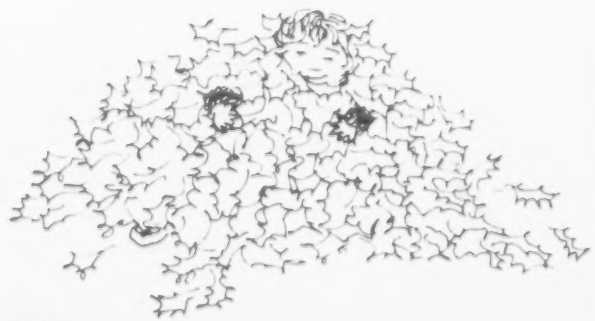
Consider Day Care a Specialty Area: The health needs of children in day care are unique and often complex. To address these needs requires specialized training and experience that can be optimally obtained by having time devoted only to this area. If possible, staff should be assigned specifically to day care activities. This practice not only allows for the development of expertise in the area but also facilitates better program planning. This would also highlight the priority of day care services and lessen the competition with the other needs of the agency. If it is impossible to have specific individuals assigned solely to day care, at least a specified portion of time should be dedicated to day care activities. Children in day care need advocates and the best advocates are those who are knowledgeable and interested in their needs. Making day care a specialty area is the first step in developing an advocacy for the health of children in day care.

Develop a Specific Day Care Plan: Although health agencies serving day care centers need flexibility in order to respond to changing needs, some overall plan including goals and measurable objectives, needs to be in place to direct a program's efforts. As was pointed out previously, the needs of day care often get lost in the activities of a large agency. The existence of a program plan would help prevent this from occurring. It would also encourage collaboration among all an agency's providers who are working with day care. Finally, a plan would help in evaluating the effectiveness and impact of the program. The latter is of critical importance if the program is going to convince others of the importance of health services in day care settings.

Broadly Define the Health Needs In Day Care: The health problems in day care include more then just communicable disease. They include such wide ranging issues as nutrition, mental health, and developmental delays. If problems in these areas aren't identified, they won't be addressed. One of the roles of a healthy agency is to make sure that that doesn't happen. By broadly defining the health needs in day care, it is unlikely that major problems will be missed. This approach will also encourage a broad range of health care providers and agencies to become involved in day care. They will see a role for themselves and will be able to help address some of the problems.

Since the health needs of children in day care are diverse, a multi-disciplinary approach is needed to adequately address them. Ideally each agency or organization should take this multi-disciplinary approach, but this is impractical. However, if the overall approach in a community is a multi-disciplinary one and one that is well coordinated, much progress will be made in improving the quality of day care.

Encourage Collaboration: Adequately addressing the health needs of children in day care is beyond the scope of any one agency. A cooperative and collaborative effort of health, education, and social service providers is necessary to accomplish this task. A collaborative approach is necessary to secure all the resources and expertise that is available for this effort. A consortium of providers is also a good mechanism for advocating improved child care and making it a priority issue for the community. The health of children in child care is a community-wide issue and needs to be addressed by a community-wide approach.



Communicable disease management and first aid/accident prevention training in day care

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INTRODUCTION

The population of the Seattle-King County metropolitan area is 1,269,749, representing one-third of Washington state's population. Of the population 78,525 are ages five years or younger. Geographically, King County is one of the largest counties in the nation. It contains urban, suburban and rural areas and sustains a large industrial base. According to 1980 census data, the King County median family income is $25,333 and the median household income is $20,717. The total number of families headed by females with no husband present and with children less than 18 years numbered 27,298 and comprised 8.4% of the families in King County. Census data from 1980 also indicated that 56.6% of women 16 years of age and older are working.

Each day nearly half of the children in this country under the age of 6 years, an estimated 11 million, are in full- or part-time day care in a variety of settings. Estimates are that approximately 25,000 children in King County under the age of 6 years are cared for in licensed child day care centers, mini-centers and homes. There are approximately 1900 licensed child day care sites in King County, Washington. Licensure is required for any person providing care for children other than their own children for more than four hours per day. Table 1 contains data on the number of day care sites by their licensure status.

TABLE 1.

Number of Child Day Care Sites by Licensure Type, Seattle-King County, 1986

Licensure Type	Number of Child Day Care Sites
Day Care Centers (Licensed for 13 or more children)	285
Mini-centers (Licensed for 7-12 Children)	119
Homes (Licensed for 6 or fewer children)	1,477

Statistics concerning the number of children in King County who are in unlicensed or informal care are unavailable. This is unfortunate as local government and business are interested in this kind of information as they begin to respond to the increasing demand for child care services.

The Seattle-King County day care community has recently experienced a considerable amount of activity and change which has been positive but which has lacked coordination. A community task force has been convened recently to determine what services presently exist, what additional services might be needed and how all of this could be organized more effectively.

For the purposes of discussion, the components of the day care community can be categorized as follows: (1) Technical assistance and training, (2) Child care subsidies, (3) Services for day care parents, and

(4) Support and professional organizations within the day care community. Technical assistance and training is provided by the Seattle-King County Department of Public Health, the community colleges, vocational training schools and the City of Seattle Department of Human Resources. These agencies provide training and assistance in health and safety, early childhood education and administration respectively. The City of Seattle Department of Human Resources recently obtained public and private funds to start a resource center for families and child care providers. So far, the major activities of the resource center have been to organize training and to develop a newsletter which is published every two months.

Child care subsidies are available to low income families via two main routes. The Washington State Department of Social and Health Services allocates a certain portion of their "welfare" monies for child care and the City of Seattle Department of Human Resources uses Community Development Block Grant funds and work incentive monies to subsidize child care.

The major service available to day care parents is the Day Care Referral Line. This is a computerized information system which provides parents with information and assistance in locating child care. The Day Care Referral Line is also a good source of information about the number, types and locations of licensed day care facilities.

There are two major support groups within the day care community: the Family Day Care Home Association and the Day Care Center Directors' Association. During the past year these organizations have performed a large quantity of advocacy around issues such as the current crisis in liability insurance for day care providers. Seattle and King County have been fortunate to have a mayor and city and county councils who are supportive and interested in child care issues. In 1982, the Mayor began a campaign to make Seattle a more livable place for children in recognition that many families with children were leaving the city for the suburbs. A committee was created ("KidsPlace") to define the priorities in making Seattle more livable for children. Good quality child care programs came to be a priority. The health department became involved in the work of KidsPlace and began to explore how their day care services could support the development of good quality child care programs.

The Seattle-King County Department of Public Health does not have regulatory or licensing jurisdiction over child care. This activity is performed by the Washington State Department of Social and Health Services. The Seattle-King County Department of Public Health does have some broad State Board of Health powers which can be invoked when there are outbreaks of serious communicable diseases in day care facilities.

The Seattle-King County Department of Public Health employs public health nurses, health assistants, and a nutritionist to provide consultation regarding child growth and development, safety, nutrition, vision, hearing, and dental screening, and evaluation of immunization histories. Health education programs are offered at the request of day care sites for staff, students, and parents.

The Department is divided into three divisions: city, county and regional. The city and county divisions provide general day care health services including training for communicable disease prevention; and the regional division provides specific communicable disease services which include monitoring, education, and intervention when there are outbreaks of communicable disease in day care settings. Collaboration and coordination of services occurs at the staff level. Current staffing in the city division consists of 1.75 FTE public health nurses, 1.0 FTE community health services representative and .25 FTE nutritionist. Staffing in the county division is 1.0 FTE public health nurse and 1.0 FTE community service representative. There is 1.0 FTE public health nurse in the regional division. Together, this staff provides a broad range of public health services to the Seattle-King County day care community. However, the remainder of this paper will address specific activities carried out in the areas of accident prevention and communicable disease management.

COMMUNICABLE DISEASE AND ACUTE ILLNESS MANAGEMENT

Care for children in group settings raises numerous health concerns, the chief one being communicable disease transmission. Although data are not conclusive to be able to assess the relative risk of infection among children in day care settings compared to those who are not, outbreaks of important infectious diseases in child day care sites have led to valid concerns about communicable disease in these settings. Since 1982 the child day care staff and the staff of the health department's epidemiology section had noted both an increase in occurrence of serious illness in child day care settings and an increasing burden of questions regarding this topic from day care directors, parents, and health care providers. A community meeting among child day care providers and health department staff held in April of 1984 in the city of Seattle revealed not only a great deal of concern among child day care providers regarding communicable disease, but confusion over appropriate preventive health measures, lack of support from parents and health care providers, and a lack of resources for gaining assistance with these problems. A survey conducted in the summer of 1985 confirmed the results of the April, 1984 meeting and established that child day care sites should deal with illness management on a daily basis, that there is a need for child care services for ill children, and that there is seasonal variation in the need for such services. Based on these data, the Seattle-King County Department of Public Health set out to meet the following needs concerning illness prevention and management:

1. Lack of knowledge among child day care pro-

viders, parents and health care providers regarding illness prevention and illness reporting.

2. Lack of formalized health policies in most child day care facilities.

3. Lack of alternatives providing for the care of ill children.

4. Lack of a database regarding disease frequency and the determinants of disease.

The approaches required to meet these needs required that the health department consider its staffing constraints, the large number of child day care sites, and the frequency of staff turnover at these sites.

IMPLEMENTATION

To accomplish the above tasks it was determined that additional staff was needed. In the summer of 1984, requests for additional staff were made to the city and county councils. These requests were supported by statistics collected by Seattle-King County Department of Pubic Health staff; support from day care providers, parents, and the local press; and copies of communicable disease articles that had been submitted to scientific journals by health department staff. These requests were met and were critical to our success.

A HEALTH HANDBOOK FOR DAY CARE PROVIDERS

In March of 1985 a nurse epidemiologist was hired to respond to the steadily increasing concerns and requests for information concerning communicable disease prevention and control at child day care centers and to handle the complexities of illness prevention and control. The first priority of this new nursing role was to expand the knowledge and resources available regarding illness and its prevention in child day care settings. The nurse epidemiologist is available by telephone and is available to make visits to child day care sites. The nurse epidemiologist has developed a day care illness risk assessment guide that has been used at numerous educational programs sponsored by the nurse epidemiologist and the child day care nurses.

It took two years to develop the Child Day Care Health Handbook, a general health guide written by health department staff and reviewed by numerous child day care providers and health care providers. A professional writer and illustrator organized the material to make it as user friendly as possible. The city and county governments paid for the printing and distribution of the handbooks free of charge to licensed child day care sites. The handbooks have been enthusiastically received, referenced frequently, and have contributed to an increase in illness reports and a more standardized approach to illness management. Although the guide contains information about a variety of health related topics, approximately one half of the handbook contains material on illness prevention and management. Six community-wide programs were held to introduce the handbook to the day care community. Child day care nurses often use the handbook as an entree for working with child day care sites. (See Figure 1)

Figure 1.

Table of Contents
CHILD DAY CARE HEALTH HANDBOOK

	Page
Introduction	3
Preventing Illness in Day Care Settings	5
Illness	13
Children's Health Histories, Physical Exams and Immunizations	38
Preventing Accidents	40
Child Growth and Development	43
Nutrition	58
Dental Health	64
Encouraging Emotional Health and Good Behavior	66
Child Abuse	70
Community Resources	73
References and Additional Reading	75
Index	76
Handbook Evaluation and Order Form	85

Discussions regarding illness management among health department staff revealed many differences of opinions. To eliminate confusion and to standardize the health department's approach, the nurse epidemiologist in collaboration with other health professionals developed a day care illness protocol that described the illness, its significance in child day care, pertinent control measures, and models of letters that could be adapted to inform parents of an illness exposure. This product has facilitated illness management, and has decreased response time. It is anticipated that most of the letters to parents included in the protocol will be packaged together and given to the child day care sites and that the protocol will be used as a tool to educate area health care professionals regarding illness in child day care sites. Two inservices have been

offered to health department staff regarding illness prevention in child day care sites.

With an improved and stable staffing level, more opportunities have presented themselves for problem identification and planning. One result of this extra planning time is the development of curriculum guides that would allow any of the day care nurses to present information on a variety of health related topics.

An active disease reporting system to detect Haemophilus influenzae type b invasive disease and meningococcal disease was established with two area hospitals that have large pediatric units. The nurse epidemiologist telephones the two major pediatric units in the area twice a week to obtain disease data. In 1985 this system detected 33% more instances of these illnesses than in 1984. This system has allowed the health department to respond more quickly to questions regarding prophylaxis.

Contacts with King County Medical Society members, articles through the health department's Epi-Log, and participation in medical and nursing educational programs have provided the health department with opportunities to influence community practice and promote prompt reporting of day care related illnesses. Day care staff have provided student practicums for the University of Washington Schools of Nursing, Medicine, and Public Health.

CRITICAL ISSUES

One of the curriculum plans being developed in collaboration with Washington State's day care licensing program is on health policy development. It is used in a variety of educational programs. The need for this curriculum was established by requests received from child day care sites and our observations of need.

The nurse epidemiologist has supported the efforts of a local day care center to establish a child care site for ill children. Since families have become so dependent on child day care, childhood illness presents a crisis for most families. The health department will support appropriate proposals for illness care and will act as consultant to programs wishing to establish alternatives for managing care for ill children.

During the summer of 1985, a pilot study was conducted to test a disease reporting system. Based upon comments received and discussions with administration, a formal disease reporting system was established in February, 1986. This system provides a baseline on illness occurrence in day care, grants opportunities for early recognition of illness, and provides the opportunity for the health department to inform day care sites about the occurrence of various communicable diseases in the community. To provide the day care sites with feedback on their illness reports, the health department publishes day care communicable disease summaries in a day care newsletter that is circulated to all licensed child day care sites and to other interested parties.

STRENGTHS OF THE PROGRAM

Certainly most of the health department's accomplishments in this last year can be attributed to an interdisciplinary staff that works collaboratively. A supportive administration has contributed to the existence of this staff by providing the funding for extra positions, providing time for meetings and funding for educational materials.

The materials developed and the health department's approach to child day care sites have made the health department's day care staff welcome and trusted visitors to child day care sites. Further evidence of this is that the staff are actively sought to give presentations to day care sites and to answer questions.

PROBLEMS OF IMPLEMENTATION

Given the large number of child day care sites in King County and the health department's current staffing level, every child care site cannot receive the personal touch. Since child day care centers care for the largest number of children in one spot, one- on-one on-site consultation has been available to the day care centers and mini-centers. It can not be overlooked that most of child day care occurs in day care homes. To reach these sites with limited staff requires the use of audiovisual materials, existing community resources, and the telephone. Although these various means of reaching these programs have been used, it is difficult to evaluate the effectiveness of the health department's efforts. Also frequent day care staff turnover requires periodic repetition of educational programs. Since day care licensing's staffing is even more restrictive than the health department's and since our focus differs, difficulties have been experienced in gaining day care licensing's support and input.

Disagreements within the health department regarding the implementation and the scope of the day care illness reporting system have delayed its inception. Originally the surveillance system was conceptualized as being a county-wide program. Budget and staffing constraints toned down the enthusiasm for a large scale illness reporting system. Discussions involving the mode and frequency of reporting and how the data would be utilized revealed a variety of opinions on the purpose and the scope of surveillance. Early agreement was reached on the importance of an illness surveillance system as a means to evaluate the effectiveness of the day care program.

RESULTS

Since implementing the communicable disease and acute illness management program, the volume of calls received by the Seattle- King County Department of Public Health regarding illness in child day care settings has increased. In 1985, approximately 400 calls were handled by the day care nurse epidemiologist, and 101 illness outbreaks were

detected. This compares with 79 outbreaks detected in 1984 and 41 outbreaks in 1983. The general day care nurses detected 81% more day care related illnesses than in 1984. It is felt that the increase in illness outbreaks detected may be due to the health department's efforts in making day care centers more aware of illness conditions for which they should seek help and where they may receive that help. It is anticipated that once the day care illness reporting system is initiated both the volume of calls and the number of illness outbreaks detected will again double.

Efforts made have resulted in more requests from day care sites and other child care providers for training and consultation. For example, the health department staff have been acting as consultants for a child day care wishing to establish a sick child care program and have been providing assistance to a program that trains nannies.

The handbook has received national recognition. At least three hundred copies of the handbook have been sold in a total of 12 states. The handbook was presented at the American Public Health Association meeting in November, 1985 and has received positive acclaim from Centers for Disease Control.

ACCIDENT PREVENTION/ FIRST AID TRAINING

Accidents and injuries are the leading cause of death in children ages one through five. Over the last fifty years, deaths from other causes have decreased significantly while injury deaths have shown only a slow, small decline. Rivara demonstrated that nearly one-third of the traumatic deaths in children are preventable through the implementation of currently available strategies.[1] A significant number of day care staff have little or no training in early childhood education and development, let alone specific strategies to prevent injury. Furthermore, there is a tremendous turnover of day care staff which means that training needs to be continuously available. In the State of Washington, first aid and CPR training are required by Washington State Day Care Licensing Requirements, but the law states that only one individual trained in first aid and CPR needs to be present at any given time. There is no similar training requirement for safety and accident prevention.

However, Washington State Day Care Licensing regulations address environmental safety of the day care facility and require that poisons be locked up and out of reach and that children be adequately supervised.

Aronson found that the products most frequently associated with the most severe injuries in day care settings were, in descending rank, climbers, slides, hand toys and blocks, other playground equipment, doors, indoor floor surfaces, motor vehicles, swings, pebbles and rocks, and pencils. In this one study, nearly two-thirds of the injuries occurred on the playground.[2]

STEPS OF IMPLEMENTATION

Accident prevention and first aid training program activities have occurred in three areas: 1) first aid training for day care providers, 2) accident prevention and safety training for day care providers and 3) safety audits of day care facilities by environmental health staff. The Seattle-King County Department of Public Health has offered first aid training classes to day care staff for about nine years. Many day care staff would use the Health Department training to supplement the Red Cross first aid training which they had attended in order to meet State of Washington licensing requirements. A significant demand for Health Department first aid classes developed because the Health Department classes contained more content about common childhood injuries and emergencies than the Red Cross classes which were standard first aid classes. In 1983, the Health Department updated the first aid curriculum and was successful in obtaining Washington State Day Care Licensing approval of the curriculum so that attendance of the Health Department sponsored classes would allow day care staff to meet licensing requirements for first aid training.

The Seattle-King County Department of Public Health currently offers first aid and CPR training which is eight hours in length. The first four hours are first

[1] *Frederick P. Rivara, MD, MPH, "Traumatic Deaths of Children in the United States: Currently Available Prevention Strategies,"* ***Pediatrics*** *75:3, March, 1985.*

[2] *Susan A. Aronson, MD, "Injuries in Child Care,"* ***Young Children*** *38:19, 1983.*

aid training with emphasis on injuries and emergencies encountered in young children and are taught by a public health nurse. The second four hours are CPR training taught by a Fire Department paramedic. Classes are offered either all day on Saturday or in two four-hour sessions on two separate evenings. Public health nurses who teach the first aid content are certified as Red Cross First Aid Trainers. In 1985, 230 day care providers received first aid training. There is presently no charge for the first aid training classes.

Seattle-King County Department of Public Health nursing staff who work in the Day Care Health Services Program have developed and presented an accident prevention and safety curriculum to day care staff and operators. They have entitled it "Safety Considerations in the Child Care Center and Home" and the content addresses accident prevention in terms of providing a safe environment and also in terms of developmental capabilities of children and the kinds of accidents that are common at certain ages. The curriculum is usually presented on-site at various day care facilities to child care providers and to groups of day care parents. The curriculum has also been used to train community college students who are in the early childhood education programs. Day Care Health Services Program staff have also developed a curriculum for three, four and five year olds entitled "Feeling Safe". The objective of this curriculum is to promote safety awareness in preschoolers.

In 1984, the Seattle-King County Department of Public Health reorganized a small portion of environmental health services to create a pilot program called the Home Hazards Program. The intent of the program was to provide a non-regulatory service to home owners and renters which would provide them with an on-site home safety audit performed by an environmental health specialist and to provide information about accident prevention and disposal of toxic household wastes such as pesticides and motor oil. The Home Hazards Program services were extended to day care facilities in 1985. Services are voluntary and non-regulatory. Day Care facilities are informed of the service by mail and by referral from Day Care Health Services Program staff.

STRENGTHS OF THE PROJECTS

The strengths of the first aid training classes are the following: 1) they serve as a "drawing card" to introduce day care staff to the Health Department and other services which are available through the Day Care Health Services Program and 2) the first aid training curriculum is specifically designed to meet the first aid information needs of day care providers who have young children in their care.

The strength of the accident prevention curriculums and of the home hazards safety audit is that standardized, consistent and comprehensive approaches have been developed to address the topic of accident prevention and safety. A standardized approach is the first step toward beginning to evaluate effective intervention strategies.

The Home Hazards Program staff has also found that once day care operators learn that the program is non-regulatory, they seem to open up and feel more free to ask questions about how they can make their facility more safe. Home Hazards Program staff have also been sensitive about coming up with suggestions that cost little or nothing to the home owner or day care operator.

PROBLEMS OF IMPLEMENTATION AND HOW THEY WERE ADDRESSED

The Seattle-King County Department of Public Health initially encountered some difficulty in gaining approval from Washington State Day Care Licensing for the first aid curriculum which had been developed. Final approval of the curriculum was obtained after State licensing staff reviewed the curriculum and with the stipulation that Health Department staff who teach the curriculum be certified by the Red Cross as first aid trainers.

There were no major obstacles encountered in using the accident prevention and safety curriculums to train day care staff and parents. The safety curriculum designed for use with preschool children has not yet been used at the time of this publication.

The Home Hazards Program has encountered two main problems which remain unsolved. Requests from day care operators and staff for safety audits have not been great and future funding for the program is uncertain. At the present time, the program is funded by Community Development Block Grant Funds.

RESULTS

Demand for first aid training has been very good. The classes which are held in various locations in the City of Seattle attract day care operators and staff from throughout King County. In 1985, 230 day care providers received first aid training. Classes are offered about once a month with attendance from twenty to thirty individuals per class. Classes are usually suspended for two months during the summer. In 1985, the Home Hazards Program performed safety audits in ten day care centers, two day care homes and six foster care homes. The most common hazards identified in order of frequency were electrical hazards, fire and burn hazards, fall hazards and a malfunctioning smoke alarm or no smoke alarm.

EVALUATION

The first aid curriculum needs to be updated in 1986. Plans are underway to review and consider using curriculums which have recently been developed for child care settings by a Red Cross chapter in San Jose, California and by the Health Department in Minneapolis, Minnesota. Day Care Health Program staff are interested in an approach which presents information on minor first aid as well as first aid for serious injuries

and also in developing a refresher first aid curriculum for those day care staff who have already taken the initial course.

The American Red Cross in King County does not currently use a curriculum which specifically addresses the needs of child care providers. Once the San Jose, California Red Cross first aid curriculum is received, the Seattle-King County Department of Public Health intends to share the curriculum with the local Red Cross to see if they have any interest in using it.

Evaluation strategies need to be developed to measure outcomes of the accident prevention and safety training curriculums. At the present time, a pre- and post test is administered but no summary data are available from these tests.

The future of the Home Hazards Program is uncertain because of potential funding reductions. If the program is eliminated, hopefully the audit procedures could be integrated into the existing Day Care Health Services Program.

RECOMMENDATIONS

It is appropriate for local health departments to be involved in providing services to child day care sites. The health department believes that these services should be limited to providing education and consultation and technical assistance, and that regulation should remain in the hands of the state government.

1. Surveillance systems to track day care illnesses and environmental accidents need to be in place. This information will provide public health professionals with baseline information about the problems and can serve as one way of measuring the effectiveness of intervening.

2. Day care staff and parents need to know how to create a safe and healthy environment for children. Education and consultation on illness management, accident prevention and first aid should be developed and presented in an organized, planned format.

3. Illness and accident prevention curricula need to be developed and evaluated for effectiveness.

4. Local health departments should recognize that child care settings are unique epidemiologic environments; and that health departments have a role in providing prevention programs.

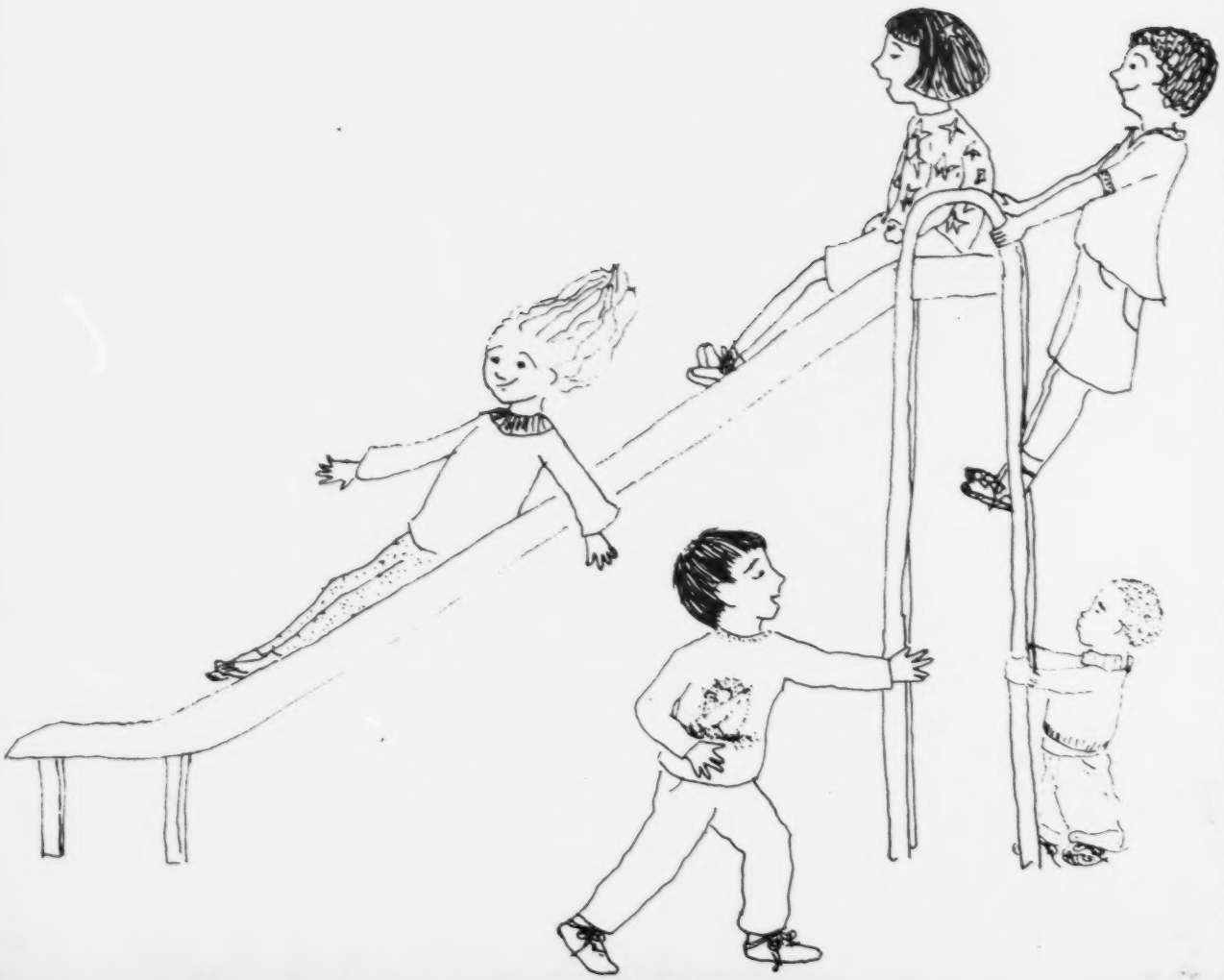
5. Guidelines for excluding the ill child from day care should be refined and standardized.

6. First aid training for child care providers needs to be tailored to meet the unique problems they will encounter while caring for young children.

7. The day care industry needs to be regulated and monitored in order to ensure children are in safe and healthy environments with adequate supervision.

The day care program at the Seattle-King County Department of Public Health has had great success due to the support it has received from the day care community, health department administration, and its committed, concerned and knowledgeable staff.

Summary comments



SUMMARY COMMENTS

The profiles of innovative public health activity concerned with the health of day care children and presented in this report speak for themselves. Collectively we believe they say that exciting public health involvement is taking place all over America with a variety of approaches being tested in many different locations. The primary purpose of this project was to report a sampling of things that were occurring. We believe this reporting will constitute a dynamic for further innovative actions in an increasing number of locales.

To conclude this report we have asked the four professional consultants to the project to make a summary comment on the Profile Conference and to suggest future directions.

GEORGE STERNE, M.D.

Dr. Sterne elected to comment on the need for the public health field to become increasingly aware of the problems of dealing with the health of the day care child.

"Day care offers unique opportunities for public health practitioners to improve the health and safety of children by providing access to large numbers of children at an early age, when interventions are likely to be effective.

"There is no question that day care is here to stay. Increasingly higher percentages of mothers of preschool children are entering the work force and there is no evidence that this trend is likely to decrease; all projections are that the percentages and numbers will *increase* in the near future. The key question is not 'Will we have day-care?,' but 'What kind of day-care will we have and what can we do to protect children in day-care?.'

"Public health practitioners come from a variety of disciplines, including epidemiology, maternal and child health, nursing, nutrition, child development, sanitation and environmental safety, all of which are important in day care. Through their relationships with government entities responsible for licensing, environmental safety, infectious disease control, etc., public health practitioners have access to children in day care. In these various roles they can be instrumental in the most important aspect of public health: prevention of illness and injury to children in day care.

"Prevention may be in the form of insuring a safe physical environment by use of recommendations and requirements regarding fire hazards, playground equipment, food handling, sewage disposal, transportation safety, immunizations, etc. The education of day care providers in basic safety prevention, first aid, sanitation, hygiene, food handling, nutrition and child development also improves the status of children in day care.

"Enforcing requirements for appropriate immunizations and tuberculin screening of children in day care and among day care providers lessens the risk of spreading infection.

"Recognition of pre-existing conditions, or those acquired during the time the child is in day care, with appropriate referral may result in earlier treatment than otherwise would have occurred.

"Screening for vision, hearing, growth and development, can be incorporated into day care routines with appropriate referrals resulting in earlier appropriate treatment.

"Treatment in the form of first aid; symptomatic treatment of common minor respiratory, gastrointestinal and skin problems; and emotional support for disturbed children can be managed in a good day care environment with the support of public health specialists.

"Day care centers in particular have been seen as sites where infection and child abuse problems have begun. However, the role of public health practitioners working with day care providers in preventing, recognizing and ameliorating these conditions has not received appropriate attention.

"Particularly in the management of outbreaks of specific diseases, e.g. Hepatitis A and Haemophilus influenzae type b infections, public health epidemiologists, nurses and physicians are the only ones in a position to see that appropriate measures are carried out. But because of varying opinions, they almost never all agree on what should be done.

"Public health practitioners, by nature of their interest, education, and experience are especially qualified to work with day care providers in minimizing the dangers to and maximizing the opportunities for positive intervention for the health and safety of children in day care."

GLEN S. BARTLETT, M.D.

In a selection from Dr. Bartlett's commentary, recommendations are made with special reference to "regulation of day care facilities by individual states."

"On the basis of these papers and the discussions related to them, the following are general recommendations relating to the regulation of day care facilities by individual states.

- There should be a more consistent and uniform definition among the states of the major subtypes of day care facilities—family day care homes, group day care centers, and preschool programs—to facilitate the development of appropriate guidelines for regulation and operation of such facilities and for the comparison of results of epidemiologic and other studies relating to day care facilities.
- There should be a set of universally accepted standards for the operation of day care facilities, such as the guidelines recently developed by the American Academy of Pediatrics, on which the individual states can base their regulations.
- There should be a clear location of responsibility for the regulation of day care services within each state's administrative structure. If responsibility is shared among separate agencies or separate divisions within

one agency, this should include a single site of 'final responsibility' for all aspects of day care regulation. If possible, the site of "final responsibility" should be located in the Department of Health within each state.

- The division responsible for regulations of day care services needs visibility and credibility within its own agency and among other agencies relating to the regulation of day care services.
- A functional and administrative distinction needs to be made between the promotion of day care services and the regulation of those services in order to avoid possible conflicts of interest.
- There needs to be adequate and stable funding of all regulatory and mandated activities in the area of child day care.

"In addition the following recommendations for the agency involved in the regulation of day care facilities are offered:

- There should be a clear legal mandate for the regulation of all aspects of day care services. This mandate should be embodied in enabling general legislation allowing for the development of specific guidelines through regulations. For example, the enabling legislation can refer to 'current health screening guidelines of the American Academy of Pediatrics' or 'definitions and procedures as embodied in applicable child abuse laws,' while the derived regulations can spell out the guidelines or procedures and how they are to be implemented.
- Current regulations should be applicable statewide and should be based on 'state of the art' guidelines relating to health, nutrition, safety, health and developmental screening, ' and developmental stimulation of children in day care.
- The regulatory agency should have the legal authority (or 'police power') to implement the regulations universally, including the authority to close nonconforming day care settings for cause.
- There should be established procedures for periodic review of existing day care regulations and mechanisms to revise the regulations as needed. These mechanisms should be widely publicized and the regulation and revision process should invite and consider public comment from affected day care facilities regarding their needs and problems.
- Regulation of the three major types of day care services—family day care homes, group day care centers, and preschool programs—should be centralized in one agency, or clearly defined interagency agreements should be developed recognizing and defining joint and separate responsibilities.
- Cooperation is essential between state, county, and municipal regulatory agencies, including a sharing of expertise in areas of regulatory inspection, health, safety, and child development. The development of manuals explaining the implementation of applicable regulations, documentation of regulatory functions, and accountability as to the adequacy of performance of regulatory functions are essential to this joint activity.
- There should be computerization of licensing records at a single central state level to facilitate record keeping and to expedite the regulatory process.
- Mechanisms should exist to identify outbreaks of infectious disease and procedures for intervening to limit the secondary spread of disease. Procedures for treatment of disease or for prophylaxis against disease, e.g. Haemophilus influenza meningitis, may need to be embodied in regulations with enforcement powers as knowledge of disease treatment and prevention expand.
- There should also be mechanisms to implement child abuse, neglect, and sexual abuse identification and referral procedures, consistent with applicable state laws and regulations.
- The regulatory agency should assume responsibility for updating day care administrators and center personnel on advances in health, safety, and child development, directly or through other organizations. They should also consider requiring as part of its regulatory function the demonstration that center personnel are keeping abreast of advances in fields relevant to their day care activities.

"These recommendations are by no means exhaustive. Other readers may very appropriately reach other conclusions and are encouraged to do so. Nevertheless, these recommendations and this report are offered as a starting point. Or perhaps more correctly, a continuation point for advancing the role of public health professionals in the field of child day care."

SUSAN ARONSON, M.D.

During the conference, Dr. Aronson identified "improving the quality of child care" as the common goal. She recommended that agencies working with child care programs use an integrated data management information system to link monitoring, licensing, training, policy, and resource development.

"At the day care site measurement of performance based on clearly defined criteria is a form of technical assistance. For the most part, child day care providers are eager to give safe and healthy care to children in their care. However, they must first understand what constitutes such care, and requests for change must be reasonable under the operational constraints of their programs. Enforcement also requires consistent and objective observations based on unambiguous requirements. Capricious, subjective interpretations do not hold up in court. Both monitoring and enforcement benefit from use of an objective assessment tool based on clear and specific regulations. Indeed, a good test of the enforceability of regulations is to attempt to draft a set of objective measures from them.

"In addition to the benefits of an instrument based system for working with individual day care sites, aggregations of data for multiple sites reveals generic problems and identifies sites whose successes might be shared. Aggregations of instrument based data on compliance facilitates analysis of patterns of compliance in communities, regions, states and the nation. New resources may be needed and regulatory or policy changes required, to permit the day care sites to achieve desired compliance. The effect of interventions aimed to change the level of compliance can be measured by changes in instrument based data.

"To collect useful data, an instrument must be developed which defines the criteria of measurement clearly and acceptably to the providers, compliance officers and technical experts alike. Such an instrument requires the recording of directly observable performance wherever possible, relying on documentation and responses of participants about performance only where direct observation is impossible. Items should be weighted by a consensus process so that dangerous non-compliance is flagged. Inter-rater reliability and validity of findings collected by such an instrument must be verified before putting the instrument into widespread use.

"After the development of a comprehensive evaluation tool, a subset of items which best predict compliance with the title set of items can be identified. This subset, or indicator checklist, can be used as a screening tool to make the most efficient use of limited staff resources. Those programs which score poorly on an indicator checklist can be investigated in greater depth using the comprehensive instrument. This type of site instrument and consensus building has been used in several states with measurable improvement in day care program quality attributable to the instrument development process itself[1].

"The specific details on the methodology for design and use of an instrument based data system are contained in a series of papers, including samples of instruments used for day care licensing and monitoring, available from Richard Fiene, PH.D., Director of Research and Information Systems, Office of Children, Youth and Families, 1514 North Second Street, Harrisburg, Pennsylvania 17102.

"Many public health departments have untapped potential for creative assistance to day care health and safety problems. We have seen examples presented as models which include licensing only; outreach consultation, training, dissemination of materials, work with providers only and work with providers, parents, health professionals and other community members. Whether as the direct monitor of the quality of day care or as the source of technical assistance on health and safety problems, health departments need a clear definition of the status of the day care programs and the children they serve. To target limited resources, objective measures of need, not just "wish lists or wants" must be obtained. Without objective, systematically collected data, neither day care providers nor site monitors will be able to make rational choices about where help is needed. The most effective health department programs have in some measure started by assessing the needs for service in the communities they serve. With an objective and continuous process of assessment, health departments can measure the effectiveness of interventions and find new needs. However, resources will always be limited so providers and consultants, those setting and enforcing standards need to focus on strategies to improve the quality of child day care for the greatest numbers of children."

[1] *Fiene, Richard and Nixon, Mark, The Instrument Based Monitoring Information System and the Indicator Checklist for Child Care. Child Care Quarterly, 14(3), Fall, 1985, p. 203.*

ALBERT CHANG, M.D., M.P.H

Dr. Chang elected to comment on community organization aspects of public health involvement in the health of day care children.

"In the past five years there has been a gratifying increase of interest in the health and safety aspects of child care programs. The selected profiles of model projects depicted in this monograph, both at the state and local level, attest to the strong dedication and creative imagination of responsible health professionals in these public health agencies.

"Yet these (with the exception of the Kansas Department of Health) are just beginning efforts, and much more needs to be done. Public health agencies have a long and successful tradition of assessing the child health needs of a community and of formulating service delivery systems to meet them. They have today a unique opportunity to become involved in the health promotion of thousands of young children enrolled in child day care programs.

Recommendations, Identified Needs and Suggested Activities

1. There is a need for a broader-based societal concern for the health and safety aspects of child care programs. Public health agencies should play a leadership role in formulating this concern.

Suggested activity: Establish a "Health in Child Care" Committee (state or local level) to serve as a forum for discussion, exchange of views, and problem solving.

2. There is a need for recognition of the health and safety aspects of child care as important public health topics. Public health agencies should become involved in these aspects as legitimate and priority areas of concern.

Suggested activity: Establish a "Child Care Health Section or Project" within the administrative unit dealing with maternal and child health services. Participation from other administrative units such as communicable diseases, nutrition services, environmental health, public health dentistry, etc. is essential.

3. There is a need for increased involvement by health agencies and health professionals in the health and safety aspects of child care. Public health agencies should play a leadership role in the planning, development, and implementation of health and safety related activities that can benefit children and families served by child care programs.

Suggested activity: The proposed "Child Care Health Section or Project" should address these issues and lead in the planning and implementation of health and safety related activities involving children in child care programs.

4. There is a need for greater interest and involvement in child care programs by health professionals from the private sector (physicians, dentists, nurse practitioners, nurses, physician assistants, nutritionists, social workers, health educators, etc.). Public health agencies should serve in a catalyst and liaison role with the private sector.

Suggested activity: The proposed "Child Care Health Section or Project" invites the input and participation of health professionals from the private sector by joint meetings, workshops, conferences, and joint involvement in specific task forces or ad hoc committees, e.g. management of mild illness, injury prevention, etc.

5. There is a need for research data, both from the epidemiological and the health care delivery system point of view, on child care programs. Public health agencies should initiate or collaborate in research activities which will generate necessary information, e.g. incidence of illness and/or injuries, nutritional status, nutrition services and education, care for the special needs child, dental health, etc.

Suggested activity: Public health agencies should initiate or participate in specific research activities which can generate this epidemiological or health care delivery system data, e.g. studies on the incidence of illness and injuries, compliance with recommended health screening tests, nutritional surveillance, etc.

6. There is a need for the development and implementation of national health and safety performance standards in child day care programs. Such standards can serve as models for state regulations and licensing requirements. Public health agencies should play a leadership role in the development of these performance standards and assist in the implementation of a number of demonstration programs.

Suggested activity: Public health agencies should collaborate with professional associations, e.g. American Academy of Pediatrics, American Public Health Associations, etc. and governmental agencies, e.g Federal Division of Maternal and Child Health, Office of Child Development, etc. in the development and field testing of these performance standards.

A CONCLUDING NOTE

We deeply appreciate the willingness of the consultants to go beyond the "call of duty" and make these comments. The comments in a sense are complementary to the profiles. They seem to help validate the operational goal of the project, namely the diffusion of innovative public health actions in behalf of day care children and their parents. The comments also give a sense of direction to the next steps and enumerate significant challenges like the refinement of data collection and its dynamic use in administrative operations (in a sense isn't it our old friend, epidemiological analysis, now applied to the health of day care children?).

Also stressed was the operational challenge of achieving optimally good day care regulatory administration especially when it is assigned as a responsibility to the state public health department. We believe these comments, like the profiles, will help sensitize the field of public health to specific operations that should be undertaken.

Patricia Schloesser
Marge Petty
Norris Class

Annotated citations of supplementary material submitted by profile writers

Several public health departments, state and local, were asked to provide supplementary material to their profiles. The response was excellent. Actually hundreds of pages of supplementary material were received! Much of it was most valuable because it specified how public health authorities are becoming increasingly involved in the health of day care children. Rather than selecting a few examples for inclusion in the appendices, we have elected to provide annotated citations of supplementary material along with addresses and telephone numbers so that any reader of the profile can find more information on topics of interest. [Patricia Schloesser, M.D.]

ARIZONA DEPARTMENT OF HEALTH SERVICES

A collection of seven documents provided by the Arizona Department of Health Services in their day care and child development service operations. (Inquiries: Arizona Department of Health Services, 1740 West Adams Street, Phoenix, Arizona 85007, (602) 241-9500.)

The seven documents are titled: 1) Guidelines for Choosing a Day Care Center; 2) Clean Hands Book; 3) "Steps in Growing," Arizona State University School of Nursing; 4) Parent/Family Involvement Outline; 5) Keeping Baby Healthy: For Use the First 12 Months, a questionnaire; 6) Parents: Infant Feeding Guidelines; 7) KIDBITS, 2 issues.

CITY OF BALTIMORE HEALTH DEPARTMENT

A collection of forms and reports used by the department in providing hearing and vision screening service to day care facilities. (Inquiries: Baltimore City Health Department, Division of Child Day Care, 303 E. Fayette Street, Second Floor, Baltimore, Maryland 21202, (301) 396-4465.)

The forms include: 1) Parental Permission for Hearing and Vision Screening; 2) Hearing Test Report; 3) Vision Test Report; 4) Hearing Screening Record; 5) Titmus Vision Screening Record; 6) Statistical Data Gathering Form Relating to Self Help Programs for Hearing and Vision Screening in Day Care Centers.

CONNECTICUT DEPARTMENT OF HEALTH SERVICES

A collection of documents relating to the child day care regulatory responsibility of the Connecticut Department of Health Services. (Inquiries: Connecticut Department of Health Services, Maternal and Child Health, 150 Washington Street, Hartford, Connecticut 06106, (203) 566-5601.)

For persons interested in state health departments as child day care regulators, this set of documents is comprehensive, well-formatted and should be educationally useful. The collection contains: 1) The state day care law as it pertains to centers and group day care homes; 2) state licensing regulations; 3) steps in seeking licensure; 4) a joint statement with Department of Human Services reporting on "reflective roles in ensuring and monitoring the health and safety of children in day care and methods of improving the service;" 5) Agreement of Department of Children and Youth Services and Health Services in respect to actions of reported child abuse and neglect, and children at risk; 6) a departmental public statement on Resources for Technical Assistance, Health and Nutrition, as it relates to the child day care licensing program; and 7) a chart on minimal control measures for Communicable Diseases in Day Care Centers.

CITY OF DALLAS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Day Care Enrichment Program: A Program of Services to Day Care Centers (Publication No. 84/85-76). (Inquiries: City of Dallas, Department of Health and Human Services, Day Care Enrichment Program, 4500 Spring Avenue, Dallas, Texas 75210, (214) 428-1358.)

This attractive, well-printed leaflet enumerates health services available to day care centers in order to promote the health and well-being of the preschool child, his family and staff of day care centers. The services offered include: 1) immunizations; 2) health services for staff; 3) health education programs for children; 4) inservice programs for caregivers and parents; 5) children with special needs; 6) hearing and vision needs; 7) communicable diseases; and 8) first aid and cardiopulmonary resuscitation classes.

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

A. A collection of educational materials relating to day care distributed by the department. (Inquiries: Child Care Licensing Section, Kansas Department of Health and Environment, Forbes Field, Topeka, Kansas 66620, (913) 862-9360.)

Titles of the leaflets: 1)"Selecting Child Care;" 2) "Winning Ways to Talk With Young Children;" and 3) "Good Health—A Gift for Your Child."

B. "Child Wards of the State," Bulletins Nos. 8 and 9, August—September, 1978, Kansas State Board of Health. (Inquiries: see above.)

This document is an interesting historical document recording pioneering efforts of the Kansas Health Department in safeguarding child care by assuring authority to act. Free xerox copies are available.

C. A collection of documents relating to the department's administrative responsibilities for child care regulation. (Inquiries: see above.)

This collection of documents includes: 1) Information sheet relative to categories of regulated child care facilities; 2)licensing registration statutes and regulations; 3) procedures for applying; 4) applications and inspection forms; 5) provider self-evaluation forms; 6) health forms.

This collection of documents should be useful for comparative study of state health departments as day care licensors.

D. State of Kansas, ex. rel., William Pringle, County Attorney, Barton County, Kansas, Kansas Supreme Court Case No. 84-56578-AS. (Inquiries: see above.)

The issue of the state's authority to regulate church-sponsored day care facilities is of national significance. The cited case is one in which the Kansas Department of Health and Environment was successful at the State Supreme Court level in holding that requiring a church connected facility to be licensed is not in violation of the First Amendment of the United States Constitution.

LAWRENCE-DOUGLAS COUNTY (KANSAS) HEALTH DEPARTMENT

A. A collection of educational materials relative to the department's day care regulatory operations. (Inquiries: Lawrence-Douglas County Health Department, 336 Missouri, Suite 201, Lawrence, Kansas 66044, (913) 843-0721.)

Specific items in this material relate to: 1) preapplication information; 2) safety aspects of child care; 3) developmentally appropriate play equipment; 4) investigatory activities; 5) policies relating to illness of day care children; 6) health policies; 7) safety; and 8) control of infectious diseases.

State statutes, regulations and forms may be obtained from the Lawrence-Douglas County Health Department as well as from the State Department of Health and Environment.

B. A copy of the local department's fiscal year 1986 contract with the state to carry out the child care regulatory program at the local level. (Inquiries: see above.)

This document is the contractual agreement between the state department and the county health department. It details the responsibilities of each in conducting the child care licensing program in Kansas.

C. Giardiasis Manual: Detection and Control in Child Care Facilities. (Inquiries: see above.)

This document is an excellent achievement in community education by a local department of health. This procedure manual relating to giardiasis was developed after its occurrence in child care facilities in Lawrence. The department had assistance from the Centers for Disease Control in evaluating the giardiasis outbreak. Copies may be purchased from the department at a price of $15 each.

MARIN COUNTY (CALIFORNIA) DEPARTMENT OF HEALTH AND HUMAN SERVICES

A. Marin County—Project Care for Children, Child Emergency and Medical Guidelines, 1986. (Inquiries: Marin County—Project Care for Children, 828 Mission Avenue, San Rafael, California 94901, (415) 454-7957.)

This practical child emergency and medical guideline, both for parents and child care providers, is well-formatted and indexed for immediate practical use. Nineteen guideline statements are presented: 1) Abdominal Pain; 2) Bites—Animal and Insects; 3) Bleeding; 4) Burns; 5) Broken Bones and Suspected Sprain Injuries; 6) Convulsions; 7) Fainting, Shock, and Lack of Breathing; 8) Ears; 9) Eyes; 10) Cuts, Abrasions and Lacerations; 11) Choking and Foreign Bodies; 12) Headaches and Head Injuries; 13) Nose Bleeds; 14) Toothaches and Broken Teeth; 15) Communicable Diseases; 16) Poisons; 17) Drowning and CPR (Cardio-Pulmonary Resuscitation); 18) Dental Emergencies; and 19) Infectious Diseases and Control.

B. *Health Education Protocols for Providers of Parent Education: Children from Birth to 6 Years of Age.* (Inquiries: Marin County Department of Health and Human Services, Health Education, Room 280, Civic Center, San Rafael, California 94903, (415) 499-6869.)

This document is an extensive collection of client-oriented health education objectives (or "memory joggers") designed for staff who wish to give comprehensive care and education, including healthy child development and related parenting issues, to parents. The education protocols represent a two-year project by a Maternal and Child Health Steering Committee, with leadership from local health department/health education and input from a community group of health professionals, parents and educators. Another document titled "Parent Health Education Checklists" has been designed to accompany the health education protocols in order to plan, track and document health education activities.

C. A collection of eleven health education booklets on child health developed by the Health Education Unit, the Division of Health Services. (Inquiries: see above.)

The titles of these short, well-written, and well-formatted booklets are: 1) Your Child, Birth to 1 Month; 2) Your Child, 1 to 2 Months; 3) Your Child, 3 to 4 Months; 4) Your Child, 5 to 6 Months; 5) Your Child, 7 to 9 Months; 6) Your Child, 10 to 12 Months; 7) Your Child 13 to 17 Months; 8) Your Child, 18 to 23 Months; 9) Your Child, 2 Years; 10) Your Child, 3 Years; and 11) Your Child, 4 to 5 Years. These are designed to accompany *Health Education Protocols* (Birth—6 Years).

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

terial relating to Maryland's reliability study in inspecion visits. (Inquiries: Maryland Department of Health and Mental Hygiene, 201 West Preston Street, Baltimore, Maryland 21201, (301) 225-6744.)

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF PUBLIC HEALTH

Two survey documents relating to Massachusetts initiative for health in day care: 1) Family Day Care Health Improvement Project and 2) Preschool Health Initiative Day Care Center Survey. (Inquiries: Preschool Health Program, Division of Family Services, Massachusetts Department of Public Health, 150 Tremont Street, Boston, Massachusetts 02116, (617) 727-0944.)

These two instruments were utilized by the Public Health Department to assess needs and in policy planning.

MINNEAPOLIS HEALTH DEPARTMENT

A. A collection of three leaflets (flyers) announcing the availability of slide presentations relating to child care. (Inquiries: Minneapolis Health Department, 250 South Fourth Street, Minneapolis, Minnesota 55415 (612) 348-2700.)

The three slide presentations ("educational tools for the child care professional") are concerned with: 1) common childhood illness; 2) minor first aid; and 3) child abuse/neglect.

B. Survey of health services for child health centers. (Inquiries: see above.)

This is an on-site survey instrument designed for use by the public health nurse. The record form provides for "plan for improvement" and "time frame for deficiency noted." The survey is part of a comprehensive record maintained for child care centers.

C. *Child Health Guidelines.* (Inquiries: see above.)

A manual presenting comprehensive guidelines in the areas of health, safety, abuse, nutrition, food handling, and child care. Sample forms are also included.

MISSISSIPPI STATE BOARD OF HEALTH

A collection of documents relating to regulations and nutrition guidelines. (Inquiries: Mississippi State Board of Health, P.O. Box 1700, Jackson, Mississippi 39205, (601) 982-6505.)

A. Regulations governing Licensure of Child Care Facilities, Miss. Department of Health, revised 1986.

B. Minimum Standards for Nutrition Care in Child Care Facilities, Miss. Department of Health, revised 1986.

C. Guidelines for Nutrition Evaluation Visits Based on Child Care Regulations.

D. Guidelines for Conducting Nutrition Evaluation Visits in Child Care Centers.

E. Nutritionist Evaluation Form for Child Care Facilities, Form No. 72-A.

NEW HAMPSHIRE DIVISION OF PUBLIC HEALTH

A. New Hampshire Division of Public Health. A collection of child care and child placing agency licensing statutes and standards. (Inquiries: New Hampshire Division of Public Health Services, Bureau of Child Care Standards and Licensing, 6 Hazen Drive, Concord, New Hampshire 03301-6527, (603) 271-4624.

The New Hampshire Division of Public Health has responsibility for defined child care regulations. Besides the licensing statute, this collection contains: 1) Child Day Care Licensing and Operating Standards and 2) Child Care Residential Licensing and Operating Standards.

B. A miscellaneous collection of forms utilized by the Division in carrying out its licensing responsibility. (Inquiries: see above.)

This miscellany of licensing forms includes: 1) Request for Child Care Investigation; 2) Intake Form; 3) Complaint Log; 4) Inspection Log; 5) Child Care Licensing Site Visit Report; and 6) Licensing/Monitoring Procedures. The collection also includes a sample computer printout of the types of licensed facilities.

C. A collection of procedure forms developed by the Division of Public Health relating to safety, health and well-being of children in day care. (Inquiries: see above.)

This collection of procedure forms includes: 1) Emergency Procedure; 2) Field Trip Permission; 3) Child Day Care Accident Report; 4) Playground Safety Checklist; 5) Fire Drill Log; 6) First Aid Supplies; 7) Transportation Permission; 8) Menu for the Week of _____; 9) Authorization to Dispense Medication; 10) Accident Prevention Tips; 11) Toddler Tales; 12) Toilet Training; and 13) When a Child Bites.

D. A collection of material developed by the New Hampshire Division of Public Health in relation to employer supported day care. (Inquiries: see above.)

This collection of material represents the Division's attempt to interpret and provide a technical assistance service relative to the important issue of employer-supported day care. Any state day care regulatory authority (Public Health or Human Services) currently concerned with this issue should benefit from New Hampshire's interpretive operations in the area.

SEATTLE-KING COUNTY DEPARTMENT OF PUBLIC HEALTH

A. Child Day Care Health Handbook, 1985. (Inquiries: Seattle-King County Department of Public Health, Day Care Health Program, Room 1406—Public Safety Building, Third and James, Seattle, Washington 94104, (206) 587-2761.)

This is a well organized handbook by the Seattle-King County Department of Public Health on community education relating to preventing illness in day care settings. Its 86 pages are clearly written and useful both for day care staff and consumers. There are specific sections on: 1) Preventing Illness in Day Care Settings; 2) Illness; 3) Children's Health Histories, Physical Exams and Immunizations; 4) Prevention, Accidents; 5) Child Growth and Development; 6) Nutrition; 7) Dental Health; 8) Encouraging Emotional Health and Good Behavior; 9) Child Abuse; and 10) Community Resources. It is well formatted and indexed. The listed price is $8 per copy.

B. A collection of community education brochures utilized by the department to reduce home hazards to health. (Inquiries: see above.)

Brochures developed by the department have the following titles: 1) Is Your Home Hazardous to Your Health?; 2) Household and Garden Pesticides Safety; 3) Noise; and 4) Formaldehyde.

C. Day Care Infection Control Protocols. (Inquiries: see above—Room 1200.)

This is a comprehensive document containing 78 pages of information by and primarily for the staff of the Epidemiology Section of the Department to establish guidelines for illness management in child day care sites. The manual contains information regarding 31 diseases (alphabetically arranged), public health control measures and letters that can be used to disseminate information regarding communicable diseases. These letters may be distributed by the day care agency to the families when a particular illness is detected. The present manual was published in December 1985 and plans call for an annual update. The listed price is $6 per copy.

D. A collection of documents relating to accident prevention, first aid, communicable disease risk assessment. (Inquiries: Seattle-King County Department of Public Health, County Day Care Program, 2424—156 NE, Bellevue, Washington 98007, (206) 344-6882.) This collection contains a course outline on the prevention and treatment of illness and injury in day care children. Included are: 1) A statement on safety considerations in the child care center and home; 2) An outline on safety considerations by developmental stage and developmental task; 3) A questionnaire on preventing accidents; 4) A quiz on health and safety; 5) A community education poster on feeling safe; and 6) A questionnaire entitled "Disease Prevention and Control Self-Assessment Guide".

An inquiry into the health of children in day care

In December, 1985 a questionnaire entitled, Inquiry: Health of Children in Day Care was formulated and sent to state Maternal and Child Health and Crippled Children's units (see below). The purpose of this questionnaire was to quickly obtain some beginning "intelligence" of current public health activities for the profile conference and publication. Thirty states responded to the inquiry, some fully and some in part—a 60% return! Excluded from this summary report are the seven states which presented a profile chapter: Massachusetts, Connecticut, New Hampshire, Maryland, Mississippi, Kansas and Arizona.

Following are summary statements for the 23 non-profile states.

SUMMARY STATEMENT NO. 1

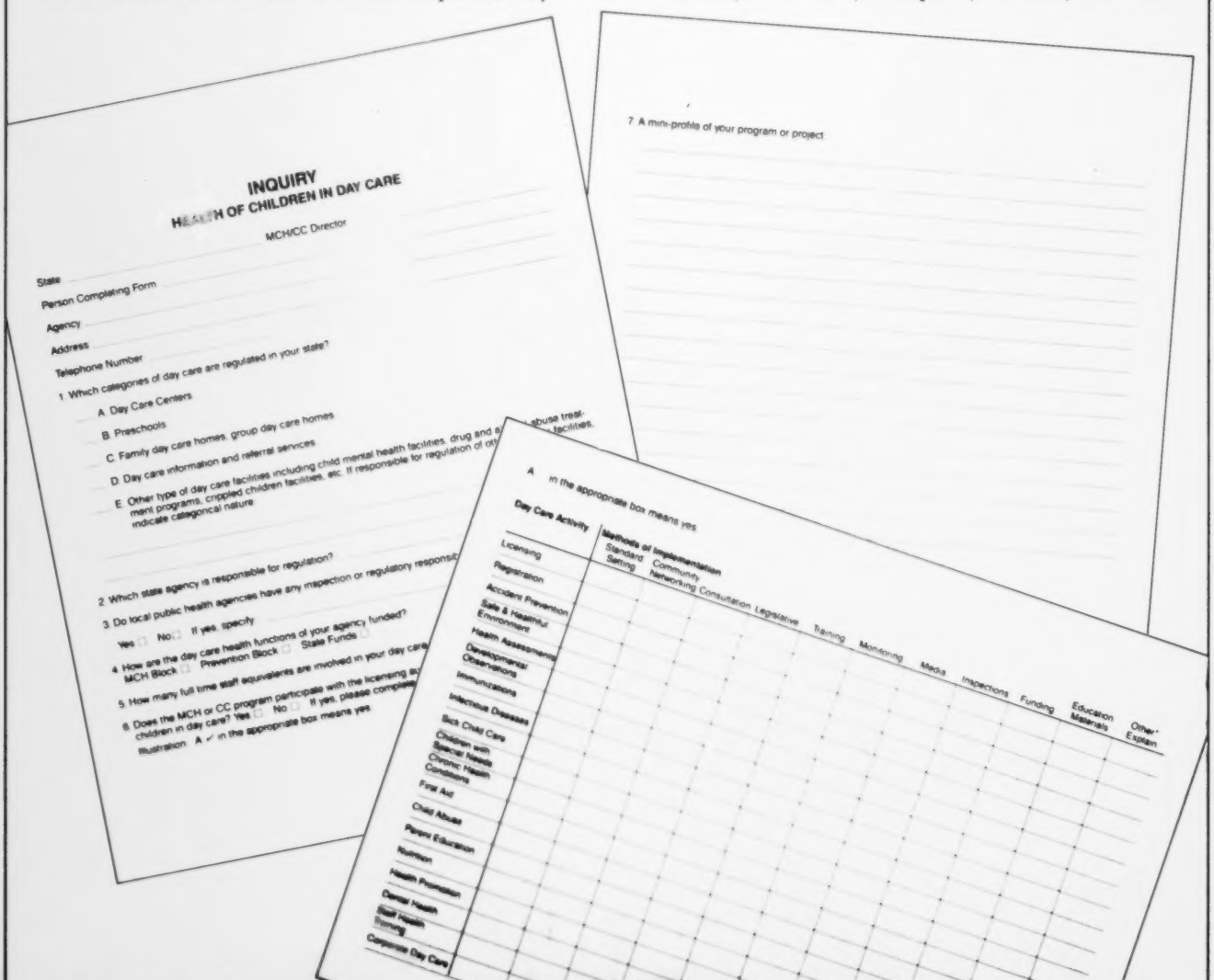
In this sampling of 23 states, all reported that some form of day care was regulated in the state and most indicated several categories of day care, i.e. day care centers, preschools, family day care and "other types" of day care facilities. In only one state in this sampling of "non-profile" states did the department of health have the formal licensure responsibility.

SUMMARY STATEMENT NO. 2:

(Relating to inquiry question: "Do local public agencies have any inspection or regulatory responsibility?") In three-fourths of the 23 states the local public health agency has a day care inspectional or regulatory responsibility. The listed local responsibility varied greatly, but sanitation would seem to be the most frequent service. Other listed services performed by local public health agencies in relation to day care included: immunization, communicable disease and food/nutrition service. Interestingly, in several instances, although the state health department does not have the formal day care licensure responsibility, the local public health department staff participates in the investigation and licensing processes in an intensive manner.

SUMMARY STATEMENT NO. 3:

(Relating to the question: "How are the day care health functions funded?") About 50 percent of the 23 states rely in whole (ten states) or in part (two states) upon "state funds." Four states rely on "MCH Block" in whole (three states) or in part (one state). One state


INQUIRY
HEALTH OF CHILDREN IN DAY CARE
MCH/CC Director
State
Person Completing Form
Agency
Address
Telephone Number
1. Which categories of day care are regulated in your state?
A. Day Care Centers
B. Preschools
C. Family day care homes, group day care homes
D. Day care information and referral services
E. Other type of day care facilities including child mental health facilities, drug and
ment programs, crippled children facilities, etc. If responsible for regulation of
indicate categorical nature
2. Which state agency is responsible for regulation?
3. Do local public health agencies have any inspection or regulatory responsi
Yes ☐ No ☐ If yes, specify
4. How are the day care health functions of your agency funded?
MCH Block ☐ Prevention Block ☐ State Funds ☐
5. How many full time staff equivalents are involved in your day care
6. Does the MCH or CC program participate with the licensing a
children in day care? Yes ☐ No ☐ If yes, please complete
Illustration: A ✓ in the appropriate box means yes
7. A mini-profile of your program or project
A in the appropriate box means yes
Day Care Activity
Methods of Implementation
Standard Setting
Community Networking
Consultation
Legislative
Training
Monitoring
Media
Inspections
Funding
Education Materials
Other-Explain
Licensing
Registration
Accident Prevention
Safe & Healthful Environment
Health Assessments
Developmental Observations
Immunizations
Infectious Diseases
Sick Child Care
Children with Special Health Problems
Chronic Health Conditions
First Aid
Child Abuse
Parent Education
Nutrition
Health Promotion
Dental Health
Staff Health
Training
Centralize Day Care

relied in part on "Prevention Block" in addition to the other two categories. Six states, over 25% of the sampling, indicated no funds are available, at least under these categorical headings.

SUMMARY STATEMENT NO. 4:

(Relating to the question: "How much full time staff are involved in your day care effort?") This question tended to be non-productive with only eight states responding with a number other than zero. The question should be restated for use in later data-gathering operations relating to public health staff committed to the day care area.

SUMMARY STATEMENT NO. 5:

(Relating to the question: "Does the MCH or CC program participate with the licensing authority in activities to promote the health of children? Yes or No. If yes, please complete activities and method on page two of inquiry.") Of the 23 states, 11 answered yes. The three most frequent methods used were: "consultation" (seven states), "standard setting" (six states), and "education material" (six states). One state indicated that it uses nine of the ten methods listed on the schedule. This latter response is similar to responses by the six profile states with the regulatory authority for day care.

SUMMARY STATEMENT NO. 6:

(Relating to the question: "Give a mini-profile of your program or project.") There was marked diversity in the nature of the comments. Most reported activities could be categorized as follows.

1. The health department provides a direct service(s) to day care children or day care facilities.

2. Consultation, training or technical assistance is provided by health department to day care facilities/consumers.

3. A regulatory activity such as formulating or helping with the formulation of standards, inspection, supervision, license issuance or enforcement action is provided by the health department.

4. The health department provides a community day care organization activity including promoting child health and development, advocacy, research and demonstration and community coordinating, with special reference to safeguarding or upgrading day care.

Overall, the questionnaire revealed that public health at both state and local levels is much involved in safeguarding and upgrading day care. The participation varies from locale to locale, is often fragmentary, and is in need of conceptual thinking by the field of public health as a whole.

The complete or excerpted comments from 18 selected states are presented as "mini-profiles" to reflect the diversity of activities.

Mini-profiles

FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

Two programs in Florida's Department of Health and Rehabilitative Services (the umbrella health, social and rehabilitative services agency) share primary responsibility for the licensure, inspection and monitoring of child day care. They are the Children, Youth and Families (CYF) Program and the Office of Licensure and Certification.

Florida is composed of 67 counties, each having a county health unit. Those professionals primarily involved with child day care are public health nurses and nutritionists. However, involvement is not uniform throughout the 67 counties. The CYF and health program offices (state level) are currently working together to promote greater uniformity.

CYF and the Office of Licensure and Certification's primary responsibility for regulation is accomplished through standard setting, consultation, training and inspections. Direct services are offered for health assessments, screenings, and immunizations for both children and day care workers. These two programs plus the Crippled Children's Program are extensively involved in Florida child day care.

GEORGIA DIVISION OF PUBLIC HEALTH

Although the Division of Public Health does not work directly with the licensing authority, the Office of Regulatory Services, also located within the Department of Human resources, it does assist day care programs in promoting health care. The Epidemiology Office assists day care personnel in controlling disease through investigation, monitoring and training. The Child Health Office provides training in creating a safe and healthful environment, proper nutrition, and prevention of child abuse. The office also trains the public health nurses who provide training for day care staff.

Georgia's Division of Public Health's involvement in child day care lies in the investigation of infectious diseases. Consultation, training, and monitoring are used to assist day care programs.

HAWAII STATE DEPARTMENT OF HEALTH

A day care program does not exist in the MCH/CC programs of the Hawaii State Department of Health. Day programs for children 0-3 years are operated on a private or voluntary basis and are licensed by the Department of Social Services and Housing.

Children three years and over with special needs are eligible for Department of Education classes. A statewide system of infant development programs is available for children 0-3 years with developmental disabilities. These programs are operated by the Department of Health or funded on a contractual basis with voluntary agencies in the community. They are not considered day care programs but rather are treatment programs designed to maximize the child's development, to minimize the disability, and to teach and support the family in assuming primary responsibility.

Most of the available services are provided through the public health nursing branch and some through the nutrition branch. Neither of these branches are organizationally with the Family Health Services Division which includes Maternal and Child Health and Crippled Children's Services. However, these branches provide much of the direct and consultative services, which are the core of our MCH/CC programs. Sanitation inspections are regularly requested and provided for the day care program.

IDAHO DEPARTMENT OF HEALTH AND WELFARE

Idaho is probably the last state to have mandatory day care licensing statewide. County regulations are enforced. This year, however, support has been generated throughout the state to encourage statewide regulation of child care.

The Idaho Division of Health and one of our seven district health departments have recently developed a training program for day care providers. Seven day care provider workshops are being offered throughout the state and teaching materials are being made available to the local health departments. This project has been quite successful and should have an impact on the quality of care that children receive. At least two counties are considering ordinances to make a training course mandatory for all operators of day care. Local public health agencies are also involved in the enforcement of county regulations.

IOWA DEPARTMENT OF HEALTH

MCH in Iowa has no legislative mandate in child care. However, the MCH programs, in general, provide a large proportion of the child health supervision of the children in day care and in Head Start.

Child health supervision includes immunization, well child supervision, health promotion, dental health, social assessment, and nutrition (including WIC). MCH, along with the Disease Prevention Division, provides day care licensing with consultation and guidance for the control of communicable disease.

KENTUCKY DEPARTMENT OF HUMAN RESOURCES

Kentucky regulations state that any facility caring for more than "three non-related children: must be licensed. The state agency responsible for regulation is the Cabinet for Human Resources, Office of the

Inspector General. Local public health agencies have the responsibility for sanitation inspections.

LOUISIANA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Although neither the Louisiana CC Program (Handicapped Children's Services) or the MCH Program have a separate formalized day care program, there are a number of services which they and other programs provide within the Office of Prevention and Public Health Services to day care centers. The nutrition section provides dietary consultations; the communicable disease section responds to requests for services and surveys for immunization status. The communicable disease section is also planning statewide inservice programs on infectious diseases in response to CDC recommendations., The Eye Anomalies and Communicative Disorders Section provide vision and hearing screening. Sanitarians at local health units provide facility inspections.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES

In New Jersey, day care centers, preschools and special care facilities are regulated by the New Jersey Department of Human Services, Division of Youth and Family Services, Bureau of Licensing. Local public health agencies are responsible for assuring local compliance with the state sanitary codes regarding lead poisoning, communicable disease, immunization and youth camp safety.

NEW MEXICO HEALTH AND ENVIRONMENT DEPARTMENT

The section responsible for day care licensing is part of the Health Facilities and Occupational Licensing Bureau, the regulatory arm of the Department of Health and Environment. Licensing is mandated by means of the Public Health Act to protect the health, safety and welfare of clients using the facilities licensed by the department. The Licensing Health Related Facilities section regulates child care centers. family day care homes, boarding homes, adult residential shelter care homes, diagnostic and training centers, special hospitals, 24 hour child care centers, group homes, maternity homes and shelters. The section has a total staff of eleven field surveyors, one supervisor and four support staff. The Bureau also enforces the criminal records check and licensing fee regulations.

Local public health agencies have inspection or regulatory responsibility for public health conditions. Their role in day care primarily involves the setting of standards, consultation training, monitoring and inspection. The day care activities on which these methods focus are accident prevention, environmental health and safety, infectious diseases, special needs children, child abuse and health promotion.

NEW YORK DEPARTMENT OF HEALTH

The New York State Department of Health provides consultation to the New York State Departments of Civil Service and Social Services on health and safety issues affecting the day care population. Those issues include accident prevention, safe and healthy environment, health assessments, immunizations and staff health training. Local public health agencies have inspection responsibility regarding food and water.

Two day care centers are also under direct contract to loan child auto safety seats and educate low income families on their proper installation and use.

OHIO DEPARTMENT OF HUMAN SERVICES

The Ohio Department of Human Services is the regulatory agency for child day care. The Ohio Department of Health is involved with the licensing authority through the appointment of a representative on the Day Care Advisory Committee within the Department of Human Services.

The Department of Health works with the licensing authority to assist with the setting of standards on health related issues, by providing consultation and education on such topics as accident prevention, health screening, infectious diseases, first aid and dental health. The Department is also a direct resource for child day care providers.

OREGON STATE HEALTH DIVISION

The Oregon State Health Division and County Health Departments share regulatory responsibility for the immunization requirements in child day care. The Oregon School/Facility Immunization Law covers all certified day care centers. All new clients must have at least one dose Diphtheria/Tetanus containing vaccine, polio, and measles/mumps/rubella to be enrolled. At least once a year each child is monitored to ensure that his immunization record is up to date. There is an exclusion clause for children in non-compliance. The Oregon State Health Division is coordinating an advisory committee on infectious diseases in day care centers. County health departments are also responsible for surveillance and outbreak control activities.

State and county sanitarians inspect primarily for food service (also water and sewage disposal, if day care home has individual water and sewage system, i.e. private well and septic tank).

RHODE ISLAND DEPARTMENT OF HEALTH

In accordance with Rhode Island General Law 40-13-5, before a license to operate a day nursery is issued, the facility must be inspected by the state fire marshal's office and a sanitarian from the Department of Health.

The Immunization Program of the Division of Disease Control in the Department of Health serves a consultative role in the area of child day care. Staff annually assess compliance to the immunization regulations by requesting a report from each center. This information is compiled into a preschool immunization assessment book. As a follow-up, approximately seven percent of these schools/centers are visited to validate the reports submitted and to provide consultative services.

The Division of Food Protection and Sanitation monitors environmental conditions relating to food, food service and waste disposal in day care centers and nursery schools. Private water systems falling under the Safe Drinking Water Act are monitored and tested four times a year.

SOUTH DAKOTA STATE DEPARTMENT OF HEALTH

The Maternal and Child Health Program has provided funding for day care home provider training and for air time for public service announcements to encourage parents to be good consumers of day care. Each of these projects is being co-sponsored by the Department of Social Services and is statewide in its impact.

The South Dakota MCH program is an extensive training resource for day care programs including issues such as accident prevention, environmental safety, infectious disease, sick child care, parent education and nutrition.

UTAH DEPARTMENT OF HEALTH

Day care programs are regulated in Utah by the Social Services Department. The Utah Department of Health provides consultation, education and legislative support to the licensing authority to promote the health of children in day care. Public health is involved with setting standards on health related issues. It is also actively involved in nutrition at day care centers. Local health agencies have responsibility for sanitation inspection.

VERMONT DEPARTMENT OF HEALTH

The Vermont Department of Health, Medical Services division personnel, Central and District Offices, provide other governmental agencies with consultative assistance in regard to health care of children in day care services. In certain instances public health staff nurses serve day care facilities on a part-time basis, usually as advisors, but may perform health assessments, health screenings and offer educational programs for staff.

In addition, Health Department Medical Care personnel regulate and certify the one Vermont facility which offers care for crippled children or children with long term illnesses.

The Vermont Departments of SRS and Health are collaborating in an effort to prevent child sexual abuse among preschool children. Prevention education for the preschoolers' parents will be the focus of this new program. Preschool children are at substantial risk for becoming sexually victimized by adult as well as adolescent offenders. SRS reports that 26% of the child sexual abuse victims in 1984 were 0-6 years old. The Health Department's study of adolescent sex offenders found that almost half of the victims were between the ages of two and six.

Currently, SRS's Child Care Training Program employs part-time trainers throughout the state to work with child care providers. This new program will allow trainers (and other community-based groups to deliver prevention education to the parents of preschool children at their day care and local community centers. The prevention education classes will begin in April and continue through February 1987.

VIRGINIA DEPARTMENT OF HEALTH

Virginia's Department of Health is particularly involved in child day care through community networking, consultation and education activities. Local health departments have regulatory or inspection responsibilities, but the state regulatory authority is an interagency responsibility of the Department of Health and the Department of Social Services.

WISCONSIN DIVISION OF HEALTH

Public health in Wisconsin is actively involved in child day care through the Division of Health at a state level and through local public health agencies. The primary function of licensing, handled through the Department of Health and Social Services, is to create a safe and healthful environment.

Local agencies provide consultation, training and community networking on injury prevention and infectious diseases. Local public health involvement in health assessments is provided through community networking. Programs on health promotion, first aid, and parenting education varies with the local resource.

In addition, comprehensive day care and nursery school health services are provided to preschool children with emphasis on screening, referral and diagnostic therapy for hearing, speech and language disorders.

An MCH project is being developed to provide services to 40 full group licensed day care centers in the city of Madison which includes approximately 1500 children and their families and 300 day care staff members. These services will include: development of a communicable disease course which will be piloted among day care personnel; education of the staff and children regarding communicable disease prevention and control; creation of a disease reporting/surveillance system; policy recommendations for day care centers regarding the management of common health problems; the development of quarterly newsletters with childhood injury/prevention information; and the statistical analysis of screening data.

Selected bibliography

The nature of this project which spans most areas of public health, is not conducive to the development of a standard bibliography. However, we have elected to provide the reader with beginning references under these four headings:

1. List of national private organizations concerned in various ways with the health of day care children

2. Selected references of health risks in day care facilities

3. Papers relating to the public health agency as the day care regulator

4. Works related to the theory of innovation and diffusion

Collectively, we believe they will provide a sense of direction to those who may wish to further pursue the topic of innovative public health services for America's day care children.

NATIONAL ORGANIZATIONS CONCERNED WITH THE HEALTH OF DAY CARE CHILDREN

A. American Public Health Association (APHA), 1015 15th Street, N.W., Washington, D.C. 20005, (202) 789-5600.

B. American Academy of Pediatrics (AAP), 141 Northwest Point Boulevard, P.O. Box 927, Elk Grove Village, Illinois 60009-0927, (312) 228-5005.

C. National Association for the Education of Young Children (Preschool) (NAEYC), 1834 Connecticut Avenue N.W., Washington, D.C. 20009, (202) 232-8777.

D. National Head Start Association (Preschool) (NHSA), c/o Sarah M. Greene, 1707 15th Street, E. Bradenton, Florida 33508, (813) 748-0137.

E. Child Welfare League of America (CWLA), 67 Irving Place, New York, New York, 10003, (212) 254-7410.

F. Children's Defense Fund (CDF), 122 C. Street N.W., Washington, D.C. 20001, (202) 628-8787.

G. American Humane Association (AHA), 9725 E. Hampden, Denver, Colorado 80231, (303) 695-0811.

SELECTED REFERENCES RELATING TO THE HEALTH OF DAY CARE CHILDREN

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